Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 05:45 A M Charlotte Lee Mitchell March 15, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Edgewater Anne Arundel 113 Claiborne Rd. 8. Date of Birth (Month, Day, Year) 1/26/1944 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2XF West Virginia 235-66-5643 64 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 No Directo Maryland Anne Arundel Edgewater 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 113 Claiborne Rd. 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ARINC 2 years Administrative Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Leroy Craig Margaret Vaughn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 113 Claiborne Rd., Edgewater, MD 21037 Robert W. Mitchell, Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lakemont Memorial Gardens 03/20/2008 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Males 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lerotic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 L Yes 2 No 9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 은 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

ours after death. To the Hospital o within 24 hours aft To the Funeral Di

Registrar

(Check only one)

JONES 31. Date filed (Month, Day, Year) MAR 1 9 2008

30. Name and address of person who completed sause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

06054

29d. Date signed (Month, Day, Year)

2. Date of Death

March

Day

22

Year

, 2008

3. Time of Death

16:18 AM

	Physicia	an
	/Medic	al
)	Examin	er
		9
	Funeral	
	Director	

1. Decedent's Name (First, Middle, Last)

Marie

Agnes

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d 2 should be filed within 72 hours after death with the Marylan, th and Mental Hyglene.
7 Is marked tal Hyglene.
7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2. Department of Health a Important: If item 27 Is any Injury or other trauonce.

altimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

the Hospital or Attending Physician:

Physician /Medical Examiner law requires that the death certificate be executed

Physician/Medical Examiner attending physician and for use as the burial-trar been signed by the should be detached Completed by page 2 certificate Certification: To Be this funeral After death. the within 24 hours a er death filled in by Medical

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Young)
Dec. 14, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Vear Hours Months Days 1 □ M 2 🕅 F 83 1924 203-12-6777 Dec. Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 217 No Maryland Washington Williamsport 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16831 Tammany Manor Road 21795 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∏ Yes 2 ⊡xNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. white Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Urban Ludwig Venonica (unknown) ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter H. Mostowy - husband 16831 Tammany Manor Road, Williamsport, Maryland 795 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State March 24, Hagerstown, Maryland 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 /uster 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on path line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier i 🔽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

251

32. Registrar's Signature

30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

D0063396

East Antietam Street

Hagerstown

MAD21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** RALPH ISAIAH MOSER MARCH 2008 3:48 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12814 POINT SALEM ROAD HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 X M 2 □ F Director 219-12-1390 97 AUG. 11. 1910 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 K No Director MARYLAND WASHINGTON HAGERSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12814 POINT SALEM ROAD 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 X Widowed 4 ☐ Divorced WHITE Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY MOSER 2 SADIE SHANK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARYLL A. SOUDERS/GRANDSON 65 SARAH DRIVE, DOVER, PENNSYLVANIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Dong 5 Other (Specify BOONSBORO CEMETERY 03/26/2008 BOONSBORO, MARYLAND 21. Signature of June 22. Name and Address of Facility 7606 Old national Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the attending pl IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2□ No or Attending Physician: funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural s after dea. ral Director: Aftr 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19H-3 In coloru 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Guy Wilson MYERS March 21, 2008 00:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16731 Fairview Road Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
July 20, 1 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1⊠M 2□F 89 220-10-3121 Yrs Director July 1918 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show iral", or Items 23a or 28a-f shov Examiner must be notified at Maryland Washington 1 ☐ Yes 2 K No Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 16731 Fairview Road 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 IXNo Specify: ģ Specify: white 3 XWidowed 4 ☐ Divorced Year or Dates: 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer utility company is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental John A. Myers Mary C. Rummel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne A. Myers - son of Health 16731 Fairview Rd., Hagerstown, Md. 21740 If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If injury Broadfording Cemetery 3/24/08 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed and I-tran physician a s the burial-t Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as signed by the attending I be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2000 has page 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 Tes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending Natural Injury 5 Pending 1 ☐ Yes 2 No investigation death Director: 2 Accident 6 Could not be determined 3 ☐ Suicide To the within 24 hours ...
To the Funeral Direct 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c, License number MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registr<u>ar</u> gistrar's Signatu

Division or Vital Records, P.O. Box 68760,

or Attending Physician: ours after death.

eral Director: After this certification by the funeral director. To the Hospital within 24 hours a To the Funeral C the Hospital

> State Registrar

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie H 59837 March 18, 2008 who completed o use of death (Item 23a) (Type, Print)

30. Name and address of person

1500 Forest Glen Rd., Silver Spring, MD 20910 M.D. Khanh Nguyen,

31. Date filed (Month, Day, Year) MAR 2

4 Homicide

29a, Certifier

determined

32. Registrar's Signature 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** М WILMA NELGEAN 0820 15 2008 NAVE /Medical 03 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F 84 Director 193-14-5901 11/2/1923 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. ant of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or Items 23a or 28a-1 shov ury or other traumatic event, the Medi. al Examiner must be notified at PA 1 ☐ Yes 2 No Bedford Director Bedford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3188 Reservoir Road 15522 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Co-owner Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Franklin Harkleroad Margaret Jane McCullough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvin E. Nave / Husband 3188 Reservoir Road, Bedford, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 03/19/2008 Cumberland, MD 21. Signature of uneral Service 22. Name and Address of Facility Adams Family Funeral Home. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on the death certificate be executed Due to (or as a consequence of) the burial-P.O. Box 68760, physician Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) ed by the a detached f 2 No 9 Unknown as been signed by 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions computating to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1☐ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Inpatient 2 2 ER/Outpatient 3 DOA Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

3

Registrar

31. Date filed (Month, Day, Year)

MAR 1 7 2008

29b. Signature and title of certifier

30. Name and address of person wh

mpleted cause of death (Item 23a) (Type, Print)

Oldtown Road, Cumberla

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician P^{M} March 15, 2008 9:30 Agnes Jeannette Neat /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4515 Valley View Road Middletown Frederick If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🖾 F 93 Director 214-07-4366 Oct. 12, 1914 Maryland Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland | Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4515 Valley View Road Items 23a 21769 United States er than "natural", or Items 23a the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John E. Smith Margaret C. Creighton ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Bonnie M. Andrews/ Daughter 4515 Valley View Road, Middletown, MD 21769 permit. Pages 1 a
Department of Hei
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 17, 1 ☐ Burial 2 🏖 Cremation 3 ☐ Removal from State Resthaven Crematory 4 Donation 5 Dther (Specify) 2008 Frederick, Maryland 21. Signature of Fune of Service Licenses Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the diseas shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Massive Hemmorhage 24 hrs. /Medical Due to (or as a consequence of): Examiner Peptic Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2XX No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Congestive Heart Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performe this certificate 1 Yes 2 No Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 No P funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: 5 Pending investigation (Month, Day Year) 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide determined 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. charf S. Rudman, 1103 D 17106 March 17, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael S. Rudman, M.D. 350 Montevue Lane, Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. Registras's Signature State MAR 2 4 2008 > Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULIA FAYE NAUNDORF 9:29A MARCH 20,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Director 220-16-2243 82 June 1, 1925 Virginia Usual Residence of Decedent 10c, City, Town or Location 10a. State 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5905 Dorsey Drive 21703 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Presser Claire Frock 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F Ernest E. Hill Fay Marie Cameron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lepartment of Health an Important: If item 27 is any Injury or any Injur James L. Naundorf / Son 5946 Jefferson Pike, Frederick, Maryland 21703 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gardens 3/24/08 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part | Enter the Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebro Vancular Accident A cule **Physician** DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy detached for Month 4 Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【MUnknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 2 No After this certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Certification: 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No death To the Funeral Director: completely filled in by the 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 24 and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) BOLARUM 20062223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PLAYEEN BOLARUM, TO, 196 TJO. MO, 196 TJORIVE PREDERICK, MD-21702

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17^{pay}, FREEMAN OUTLAW MARCH 2008 10:40A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing PRINCE GEORGES Center Laurel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours Min ¥XM 2□ F N.Carolina 242-09-1970 94 10,1913 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3100 Fairland Road 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) W.S.S.C. 9th Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Conday Outlaw Carrie Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14829 Belle Ami Drive, Laurel, MD 20707 Mary Williams (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Geørge WashingtonCem 3/25/08 4 □ Donation Adelphi, MD 5 Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service License 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the diseashock, or heart failur se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease l year Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a, Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

'natural", or Items 23a or 28a-f show dical Examiner must be notified at

Hygiene. other than "natur ent, the Medical E

other

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event,

Pages 1 and 2 should be nent of Health and Mental

Director

Funeral

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Completed

Be

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the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner physician and the burial-transi Physician/Medical the

certificate be executed

Division or Vital Records, P.O. Box 68760,

attending | ed by the a signed by t Completed page 2 should peen certificate Be ဥ ospital or Attending Phy hours after death. Ineral Director: After this y filled in by the funeral d Certification:

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Sequentially list conditions, fany, leading to immediate cause. Enter Underlying	Į	t
Cause (Disease or injury hat initiated events esulting in death) Last		C
		d

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1□ Yes 25. Was case referred to medical

examiner?					20.	r lace of Dea	aut (Check only one)
1 Yes 2√ N	lo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 [DOA Other: 4	Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	1	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, stree ify)	t, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D24721

Mar. 18, 2008

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

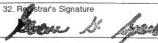
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14333 Laurel-Bowie Rd, #208, Laurel, MD 20708 Syed Sadiq, M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 2 2008



DHMH 17 Rev 1/2001

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To the within

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 U 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 MARCH 2:02 PM Shirley Elaine O'Brien /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Medical Towson Baltimore Saint Center 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Davs Months Hours Min. Director 88 496-10-3963 February 19,1920 Illinois Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sh notified 1 ☐Yes 2 K No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code a or ms 23a 428 Village Place 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? "natural", or Items dical Examiner πι 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) than 5+ Teacher Public Schools 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ John I. Hemphill Violette Ash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sharon L. O'Brien - Daughter : If item 27 428 Village Place, Hagerstown, Maryland 21742 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 03/25/2008 Fort Lincoln Crematory Brentwood, Maryland 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL INFARCTION ACUTE /Medical Due to (or as a consequence of) **Examiner** ACUTE CORONARY SYNDROME any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending physical for use as the t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Vear 4□Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s PULMONARY EDEMA autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46356 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 7621 OSLER DRIVE. TOWSON, KHOSROW TABASSI. M. D. . 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 20 2008 Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 2008 23:22 March 11, Bernard Payne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 25, 9. Birthplace (State or Foreign Country)
D. C. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1⊠M 2□F 1975 D. 577-94-9567 32 Director Usual Residence of Decedent e tiled within 72 hours after death with the Maryland at Hygiene.
other than "natural", or Itams 23s or 28s-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral', or itams 23a or 28a-f ahow Examinar must be notified at 1X Yes 2 □ No Md. Prince Georges Hyattsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4922 La Salle Road 20782 U. S. A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black ff Yes, Give 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) Day Program Day Program Special Ed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic avent once. Be Alice Payne Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Washington, DC 20005 1125 15th Street, N.W. Phyllis Anderson (Case Manager) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/19/2008 Mt. Zion Cemetery Baltimore, 22 Name and Address of Facility
W. H. Bacon Funeral Home, Inc. 21. Signature of, Funeral Service Licensee CC36/ 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final Sudden Cardi40 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown byt s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes ★☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√2 No 24a. Was an autopsy performed? certificate 2√ No 1 Yes Division of Vital Attention of the state of the s of or Attending Physician: atter death. I Director: Atter this certitica 25. Was case referred to medical Be 26. Pface of Death (Check only one) examiner? 1 X yes 2 □ No To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 VDOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: fnjury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide To the Hospitel within 24 hours a tha Hospitel 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 2326 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print)

State Registrar James Lightfoot, M.D.

31. Date filed (Month, Day, Year)

MAR 1 9 2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

7600 Carroll Ave. Takoma Park Maryland, 20912.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 15, 2008 Physician Eulalee Presley 8:30 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paint Branch Assisted Living Adelphi Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 20, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Months Days 1 🗌 M 131-40-2869 88 Director 1919 Jamaica Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show notified at 1 XYes 2 No Director MD Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be I 3601 Golden Hill Drive 20721 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CNA Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Levy Rebecca Ebanks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna McMillon - Daughter 3601 Golden Hill Dr. Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Harmony Memorial Park 3/22/2008 Landover, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Fecility Pendon/Hale Funeral Home 21. Signature Funeral Service Licens 9013 Annapolis Rd. Lanham, MD 20706 Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician Myocardial infarction/CVA /Medical Due to (or as a consequence of) **Examiner** Diabetes Sequentially list conditions, if any county to me find cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and the burial-transit Hypertension Due to (or as a consequence of) Box 68760, Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 2X No 3 Probably 4 Unknown 1 ☐ Yes certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 **X**No 1□ Yes 1 ☐ Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Asst. Living 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation (Month, Ďay Year) 1 Natural Injury death. 1 ☐ Yes 2 ☐ No or Attend after death. Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

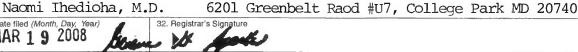
To the Hospital of within 24 hours at To the Funeral D

Medical

31. Date filed (Month, Day, Year)
MAR 1 9 2008 State Registrar

(Check only one)

29b. Signature and title of certifie



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D47838

29d. Date signed (Month, Day, Year)

March 17, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 18, Day 2008 Year **Physician POUS** 3:40 P.M Morris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Montgomery Hospice Rockville Montgomery 8. Date of Birth Month, Bay, Dec. 1, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**火** M 2□F Months Days Hours Min 493-34-7827 93 Po Tand Director Usual Residence of Decedent 10h County 10c City Town or Location 10a State 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the M-dical Examiner must be notified at Missouri 10e. Street and 1105 We XYes 2□No Kansas City Jackson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 64114 U.S.A. 1105 West 88th St. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any finury or other thaumatic event, the McGiral Examinea 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2**V** No Specify Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bole Proprietor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raizel Leah Kwart Hiyam Poznanski ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 120 Nautica Way, Roswell, GA 30076 Joel Pous/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Arlington Memorial Pk. 3/20/2008 Sandy Springs, GA 21. Signature of Funeral Serve Lio 22. Name and Address of Facility Torchinsky Hehrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Stage Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed Exami burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as for use a IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Completed 3 Probabiy 4 ☑ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has performed? res 2\lambda No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ∐ Yes 2 💢 No Other: $4\square$ Nursing Home $5\square$ Residence $6\square$ Other (Specify) Hospice 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Ki Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

MAR 20 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, MD

D0064615

1355 Piccard St., Rockville, MD

March 19, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician Medical Jeremy Wayne Poffenberger March 21 2008 5:4				1 - For State Registrar		f Marylar		artmer <i>rtificat</i>				ental Hyg	iene)	08)15
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DHMH 17 Rev 1/2001

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ä	4621 Benning Road, SE	Apt. B	20019		USA	
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timen rtmen rtmen rtmen y or o		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Name and Address of Facility J			
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ed nsit	Exal	events resulting in death) Last Due to (or a	as a consequence of):				
xecute n and - tran	ca	d. X UNPENDED AMENDE	p 23a.27.28a-f per	ME g878 4/14/08 ami	1		
	Medi		es, outcome of pregnancy			23d. Date of deliver	у
50, te be e tysiciau burial	5	23b. Was decedent pregnant in the	ve birth 2	Fetal death 3 Ectopic pre	gnancy	Month	Day Year
58760, rtificate be e ing physicial as the burial	<u> </u>	4 Pr	regnant at time of death 5	Other (Specify)			
ox 68760, ath certificate be e attending physicia or use as the burial	siciar	1 Yes 2 No 9 V Unknown g				cco use contribute to	the series of dooth?
b. Box 68760, the death certificate be ex the attending physician ched for use as the buria!	Physician/Medical E	L	ng to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba		the cause of death?
P.O. Box 68760, so that the death certificate be e gned by the attending physicial e detached for use as the burial	by Phy	- J	ng to death but not resulting in th	e underlying cause given in Part I.		2 🗸 No 3 🗌 Pro	
ds, P.O. Box 68760, equires that the death certificate be e een signed by the attending physicia ould be detached for use as the burial	by Phy	- J	ng to death but not resulting in th	e underlying cause given in Part I.	1 Yes	24b. Were a	bably 4 Unknown
cords, P.O. Box 68760, s law requires that the death certificate be e the search signed by the attending physician e 2 should be detached for use as the burial	by Phy	- J	ng to death but not resulting in th	e underlying cause given in Part I.	1 Yes 24a. Was an autopsy perform	24b. Were at prior to death?	utopsy findings availab
I Records, P.O. Box 68760, 1: The law requires that the death certificate be etificate has been signed by the attending physician, page 2 should be detached for use as the burial or, page 2 should be detached for use as the burial.	Completed by Phy	Part II. Other significant conditions contributir	ng to death but not resulting in th	e underlying cause given in Part I. 26.Place of Death (Ch	1 Yes 24a. Was an autopsy perform 1 Yes 2	24b. Were at prior to death?	utopsy findings availab
/ital Records, P.O. Box 68760, sician: The law requires that the death certificate be easiered: the certificate has been signed by the attending physician lirector, page 2 should be detached for use as the burial	Be Completed by Phy	Part II. Other significant conditions contributing contri	ng to death but not resulting in th	26.Place of Death (Ch	1 Yes 24a. Was an autopsy perform 1 Yes 2 eck only one)	24b. Were at prior to death?	bably 4 Unknown utopsy findings availab completion of cause of
of Vital Records, P.O. Box 68760, ig Physician: The law requires that the death certificate be e ther this certificate has been signed by the attending physician neral director, page 2 should be detached for use as the burial	To Be Completed by Phy	Part II. Other significant conditions contribution 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 128a. C	Inpatient 2 ER/Outpatie	26.Place of Death (Chent 3 DOA Other Note of Injury 28c. Injury at Work?	24a. Was an autopsy perform 1 Yes 24a. Was an autopsy perform 1 Yes 2 eck only one) ursing Home 5 Received the performance of the performanc	ed? 24b. Were a prior to death? 1 ✓ Y	bably 4 Unknown utopsy findings availab completion of cause of es 2 No
on of Vital Records, P.O. Box 68760, fending Physician: The law requires that the death certificate be eath. After this certificate has been signed by the attending physician the funeral director, page 2 should be detached for use as the burial	To Be Completed by Phy	Part II. Other significant conditions contributing contr	Inpatient 2 ER/Outpatie Date of Injury Honth, Day, Year)	26.Place of Death (Chern and 3 DOA Other 1 No.	1 Yes 24a. Was an autopay perform 1 Yes 2 eck only one) 28d. Describe ho Passenger	24b. Were an prior to death? No 1 ✓ Y esidence 6 ✓ Other winjury occurred	bably 4 Unknown utopsy findings availab completion of cause of es 2 No er: Scene
vision of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be effectant. After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial in by the funeral director, page 2 should be detached for use as the burial	To Be Completed by Phy	Part II. Other significant conditions contributing contr	Inpatient 2 ER/Outpatie Date of Injury Honth, Day, Year) 1:30a Place of Injury - At home, farm, si	26.Place of Death (Chent 3 DOA Other 1 Number 1 Number 1 Yes 2 X No	1 Yes 24a. Was an autopay perform 1 Yes 2 eck only one) 28d. Describe ho Passenger	24b. Were an prior to death? No 1 ✓ Y esidence 6 ✓ Other winjury occurred	bably 4 Unknown utopsy findings availab completion of cause of es 2 No er: Scene
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be eours after death. The this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial	To Be Completed by Phy	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specific Property of the Could not be determined) 4 Homicide (Specific Property of the Could not be determined)	Inpatient 2 ER/Outpatient 2 ER	26.Place of Death (Chent 3 DOA Other; Not of Injury 28c. Injury at Work? 1 Yes 2 X Not treet, factory, office building, etc.	1 Yes 24a. Was an autopsy perform 1 ✓ Yes 2 eck only one) ursing Home 5 Re 28d. Describe ho Passenger 28f. Location (Str or Town, Sta Seat PI	ed? 24b. Were an prior to death? No 1 ✓ Y esidence 6 ✓ Other winjury occurred in motor veret and Number or R te Addison Rd,	utopsy findings availab completion of cause of les 2 No er: Scene
Division of Vital Records, P.O. Box 68760, e Hospital or Attending Physician: The law requires that the death certificate be e 7.24 hours after death. - A thours after death. - Funeral Director: After this certificate has been signed by the attending physician letely filled in by the funeral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Phy	Part II. Other significant conditions contributing contr	Inpatient 2 ER/Outpatie Date of Injury fonth, Day, Year) 28b. Time of 1:30a Place of Injury - At home, farm, si cify) Roadway	26.Place of Death (Chent 3 DOA Other; No of Injury 28c. Injury at Work? 1 Yes 2 X No treet, factory, office building, etc.	24a. Was an autopsy perform Ves 2 eck only one) ursing Home 5 Re 28d. Describe ho Passenger 28f. Location (Stror Town, Sta Seat Pl	esidence 6 Other winjury occurred in motor velet and Number or Rd, and Manner as sta	utopsy findings availab completion of cause of es 2 No No er: Scene nicle accident ural Route Number, Cit, and Central eted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Direct. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification: To Be Completed by Phy	Part II. Other significant conditions contributing contr	Inpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 Seb. Time of 1:30a Place of Injury - At home, farm, since fifty) Roadway The best of my knowledge, death ocurs of examination and/or investigns.	26.Place of Death (Chent 3 DOA Other4 Not of Injury 28c. Injury at Work? 1 Yes 2 X Notreet, factory, office building, etc.	1 Yes 24a. Was an autopsy perform 1 ✓ Yes 2 eck only one) ursing Home 5 Re 28d. Describe ho Passenger 28f. Location (Str or Town, Statent Pleaser) and due to the cause (ed at the time, date ar	24b. Were an prior to death? 1 V esidence 6 V Other winjury occurred in motor velet and Number or R te Addison Rd, s) and manner as stand place, and due to t	bably 4 Unknown utopsy findings availab completion of cause of es 2 No er: Scene nicle accident ural Route Number, Ci , and Central tted. the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be eviting at hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	To Be Completed by Phy	Part II. Other significant conditions contributing contr	Inpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 ER/Outpatient 2 Seb. Time of 1:30a Place of Injury - At home, farm, since fifty) Roadway The best of my knowledge, death ocurs of examination and/or investigns.	26.Place of Death (Chent 3 DOA Other,4 Not of Injury 28c. Injury at Work? 1 Yes 2 X Not treet, factory, office building, etc. occurred at the time, date and place, gation, in my opinion, death occurred 29c. Ucense number	1 Yes 24a. Was an autopsy perform 1 ✓ Yes 2 eck only one) ursing Home 5 Re 28d. Describe ho Passenger 28f. Location (Stror Town, Sta Seat Pl	esidence 6 Other winjury occurred in motor velet and Number or Rd, M s) and manner as sta	utopsy findings availab completion of cause of les 2 No
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be evitin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Phy	Part II. Other significant conditions contributing contr	Inpatient 2 ER/Outpatient 2 ER	26.Place of Death (Chent 3 DOA Other4 Not of Injury 28c. Injury at Work? 1 Yes 2 X Notreet, factory, office building, etc.	1 Yes 24a. Was an autopsy perform 1 ✓ Yes 2 eck only one) ursing Home 5 Re 28d. Describe ho Passenger 28f. Location (Stror Town, Sta Seat Pl	24b. Were al prior to death? 1 V Y esidence 6 V Other winjury occurred in motor vereat and Number or R te Addison Rd, s) and manner as stand place, and due to to 129d. Date signed (Motor)	utopsy findings availab completion of cause of les 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12, 2008 11:55 Å Paxton Bessie Mae March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4610 Russell avenue Mt Rainer Prince George's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 3 96 Director 202-20-1714 June 10,1911 Alabama Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show iral", or Items 23a or 28a-f shov Examiner must be notified at Yes 2 No Directo Maryland Prince George's Mt Rainer 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 20712 4610 Russell Avenue by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**ÆN**o Specify. Black Specify: 3X Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Twelth Claims Examiner Government None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Alexander Edward Stanley Wells other traumatic ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Paxton/Daughter 4610 Russell Ave., Mt Rainer, MD 20712 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of h March 18, Important: If It any Injury or o ₩₩Burial 2 □Cremation 3 □Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery Washington DC 22. Name and Address of Facility Hunt Funeral Home, 908 Kennedy 21. Signature of Funeral Service Licenses St NW, Washington DC 20011 Tunt rances Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical peretension Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner true the Pulming Dixase The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 s autopsy performed: 2₽No 1 TYes 1☐ Yes 2☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 1 Inpatient 3☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Bj

Registrar

DHMH 17 Rev 1/2001

State

3415HAMITON ST HYAFTOVILL MD 20782

ompleted cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Regis ar's Signature

1 36 907

M.D. 925 Bishop Walsh Rd., Cumberland, MD 21502

March 19, 2008

Mell

Sidhu

MAR 2 0 2008

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Examiner The law requires that the death certificate be executed

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

29a. Certifier

29b. Sidna

(Check only

For State Registrar

Decedent's Name (First, Middle, Last)

attending physician and for use as the burial-tra s been signed by the should be detached After Director:

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4x Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 🔯 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: $_{4\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) \square Hospice 2X No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 🖾 Natural 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧

Certificate of Death

Reg. No.

3. Time of Death

9. Birthplace (State or Foreign Country) New York

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

2008

Montgomery

United States

Black, White, etc.

Brentwood, MD

29d. Date signed (Month, Day, Year)

3/16/2008

Specify:

14. Race - American Indian,

White

4c. County of Death

9:35 PM

2. Date of Death

To the Hospital or Attending Physician: within 24 hours a

Genevieve Wroblewski, M.D. State Registrar

ire and title of certifier

32. Resistrar's Signature

ame and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive #100, Rockville, MD 20850

D0064615

DHMH 17 Rev 1/2001

State

Registrar

Silver Spring, Maryland 20910

Ira Rabin, M.D., 1500 Forest Glen Road,

2008

egistrar's Signature

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

ď	1	19a. Informant's Name/Relationship (Type. Print)		19b. Mailing Add	ress (Street and Nun	nber or Rural F	Route Number, City	or Town, State,	Zip Code)
		Jan A. Rudisill - wife		11319 D	ogwood Dr.	, Hage	rstown, M	aryland	21740
	1	20a. Method of Disposition	20b. F	Place of Disposition (cemetery, crematory	Name of or other place)	Dat	e 20c. L	ocation - City or	Town, State
		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	ale	se Hill Co		3/25/	08 Hag	erstown	, Maryland
ouce		21. Signature of Furieral Service Licensee	•		e and Address of Fac	, III	NNICH FUN		
ō		30011/11/u	nned	415	E.Wilson	Blvd.,	Hagersto	wn, Md.	i
		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	sed the death th line.	h. Do not enter the	mode of dying, such	as cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death
n		Immediate Cause (Final disease or condition resulting in death)	Mary	arles	2 Wist	ense			yeas
r		Due to (c	as a conse	Grand and	M				ADUNE
		Sequentially list conditions, b. b. Jule 13 (o	as a consequence	LMLL uence of):					- fairs
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Į,	EXa	and the state of t	r as a consequ	uence of):					
	ca	d							
	Physician/Medical	IF FEMALE:							
1	Jan/	23b. Was decedent pregnant 12st 12 menths?	th 2 ☐ Feta	I death 3 ☐ Ectop	ic pregnancy			23d. Date of de Month	livery Day Year
	ysic	1 Yes 2 No 4 Pregna 9 Unknown 9 Unknown	nt at time of d	eath 5 Other	(specify)				,
2	2	Part II. Other significant conditions contributing to dea	th but not res	ulting in the underlying	ng cause given in Pa	rt I.	23e. Did tobacco	use contribute to	the cause of death?
3	o De	None					1 ☐ Yes 2	No 3□ P	robably 4 Unknown
1	Completed						24a. Was an	24b. Were at	utopsy findings available completion of cause of
	Ē						autopsy performed? 1 Yes 2 X No	death?	
000		25. Was case referred to medical examiner?			26. Pla	ace of Death (Check only one)		
F	2	1 Yes 2 No Hospital: 1 □ In		· · · · · · · · · · · · · · · · · · ·		Nursing Home	5 Residence	6 □Other (Spe	cify)
8	=	Jacquai J I ending	Injury Day Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe how inju	ry occurred	
1	28	2 Accident investigation 3 Suicide 6 Could not be 289 Place	finium - At he	M street for	1 Yes 2		L cooking (County	ad Normbar as D	at Day to Markey
i de la constitución de la const		4 Homicide determined 200. Flace of building	, etc. (Specify	ome, farm, street, fac y)	story, onice	201	f. Location (Street as City or Town, State	e)	urai Houte Number,
10	5	29a. Certifier 12 Certifying Physician: To the b	est of my kno	wledge, death occur	red at the time, date	and place, and	d due to the cause(s	and manner as	s stated.
Modioal		(Check only one) 2 Medical Examiner: On the base and manner	is of examina r stated.	tion and/or investiga	tion, in my opinion, o	death occurred	at the time, date an	d place, and due	e to the cause(s)
3.6	2	29b. Signature and title of pertifier			29c. License numbe	er	29d. Da	ite signed (Mont	h, Day, Year)
		MD MD			D58	113		03/2	4/08
		30. Name and address of person who completed cause	of death (Item	23a) (Type, Print)	1 11.4)	(12	. / 4	L
+04		31. Date filed (Month, Day, Year) 32.	32 pistrar's Signa	ture 5	Antieta	m St	H 203,	Maye	2174n
itate stra		MAR 2 5 2008		E ASSE					0.77
1/200	1								
				ORIGIN	AL				

W-460

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 20,2008 Joy Mae Randolph March 9:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elliott's Place Cecil Elkton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 M 2 XF 83 Director 216-20-1947 January 31,1925 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d, Inside City Limits r 28a-f sh notified 1 Yes 2 XNo Director MD Ceci1 **Elkton** 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be nonce. 20 Montrose Lane 21921 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 🏖 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David J. Randolph Elsie M. Lloyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Evans/Friend 95 Frenchtown Rd., Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State March 24 Gilpin Manor 4 ☐ Donation 5 ☐ Other (Specify) 2008 Elkton, 21. Signature of Fun ral Service 22. Name and Address of Facility Andrew G. Gee Funeral Home e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Elkton, 21921 Approximate Interval Between Onset and Death Part1. Enter the disea shock, or heart fail are Immediate Cause I all disease or condition resulting in death Physician META STATIC BREAST CARCINOJIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and I-transit Due to (or as a consequence of): physician a s the burial-Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2☑ No 24a. Was an autopsy performe page 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 SR/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No P 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760,

the death certificate be executed Division or Vital Records, or Attending death. the Hospital

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

has certificate After this certification funeral director, I Director: hours after within 24 hours a To the Funeral D

State Registra

Medical

P.V. Kingau

00065733

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 03/20/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLKTON, MA NORTH STREET. such 38 113 NARAYANA RAD. PULA

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only



08-02403	
Joelito Rios	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

pelito Rios	State of Maryland / Departme 1-For State Certifica Registrar	nt of Health and Mental H te of Death	ygiene Reg. No.	18 1102			
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year March 26, 2008	3. Time of Death 1812 hrs			
d'a	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death					
Funeral	Bowie Health Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24Hrs	. [8, Date of Birth(MM/DD/YYYY)] 9. Bir	thplace (State or			
Director	215-25-5026 1 [*] ₁ M 2 F 36	Yrs. Months Days Hours Min	04/30/1971 Foreign Co	m El Salvador			
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits			
	MD Prince George's Bowie		10g. Citizen of What Cou	1 Yes 2 No			
with the Maryland ns 23a or 28a-f sho be notified at once.	10e. Street and Number 2609 Fair Lane	10f. Zip Code 20715	El Salvado				
r death with or items 23. must be not	1 Nover Married 2 X Married Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		ican Indian, Black,			
fiter dea	1 Yes 2 A No 3 Widowed 4 Divorced If Yes, Give Year	1 XYes 2 No specify: [] S	Salvador specify: Hisp	panic			
"natural" Examine	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use ret					
5-0036 ed within 72 hour stygiene. other than "natt he Medical Exau Completed	Col	nstruction	Building				
21215-0036 and be filed within 7 Mental Hygiene. marked other than e event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Pantaleon Rios		e (First, Middle, Maiden Surname)				
O 8 5 ≈ ± 1 C		Mailing Address (Street and Number or 2609 Fair Lane Boy	Rural Route Number, City or Town, State	e, Zip Code)			
ore, MD es I and 2 sho of Health and If item 27 is ther traumati	20a. Method of Disposition 20b. Place o	Disposition (Name of cemetery,	Date 20c. Location - City o	r Town, State			
Baltimore, permit. Pages I ar Department of Hei Important: If ite	Abullai 2 Cientation 3 Removal non State	ont Mem. Gardens 4/5	/2008 Davidsony				
Baltimo permit. Page Department of Important: injury or ott	21. Signature of Funeral Service Licensee	22. Name and Address of Facility 6512 NW Crain Hy	vy. Bowie, MD 207				
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and			
*xaminer	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosc Due to (or as a consequence of):	lerotic Cardiovascular D	isease	Death			
-B	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
led Insit	cause. Enter Underlying Cause (Disease or injury that initiated						
and transit	events resulting in death) cast						
60, are be executed hysician and e burial - transit	AMENDED 23a, 27 per ME FEMALE: 23c. If yes, outcome of pregnancy	g878 4/25/08 amh	23d. Date of delive				
Box 6876 death certificat he attending phy of for use as the	23b. Was decedent pregnant in the past 12 months?	=		Day Year			
Box te death the atte ed for u	1 Yes 2 No 9 Unknown 9 Unknown						
P.O. es that the igned by be detach		in the underlying cause given in Part I.	23e. Did tobacco use contribute to	obably 4 V Unknown			
Records, P.C. The law requires that ficate has been signed to a page 2 should be deta. Completed by			autopsy prior to	utopsy findings available completion of cause of			
of Vital Records, g. Physician: The law requir offer this certificate has been so neral director, page 2 should 1. To Be Complete.			performed? death? 1 Yes 2 No 1 1				
Vital ysician: this certif director,	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 V ER/Ou	26.Place of Death (Check stpatient 3 DOA Other: Nursi	only one) ng Home 5 Residence 6 Other	er:			
ding Ph		ime of Injury 28c. Injury at Work?	28d. Describe how injury occurred				
Division of attending on after death. ral Director: After After of the death. rel Control of the function of the function of the function.	2 Accident Investigation	rm, street, factory, office building, etc.	28f. Location (Street and Number or F	tural Route Number, City			
Diversal bours at y filled Cert	4 Homicide determined (Specify)		or Town, State)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea 0ne) 2	th occurred at the time, date and place, an evestigation, in my opinion, death occurred	at the time, date and place, and due to t	he cause(s)			
L % F %	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (M March 27, 2008				
	30. Name and address of person who completed cause of death (Item 23a)	0.0.171.2.	170.07 27, 2000				
	Patricia Aronica-Pollak MD. Assistant Medical Exam		re, MD 21201				
State Registra	31. Date filed (Month, Day, Year) APR 0 1 2008 32. Registrar's Signature	D					

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #5.PerFHPCC3-25-08cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death March P4, 2008 Stoutsenberger 9:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Nursing and Rehabilitation Bethedsa Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7-20-1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 579874171 Usual Residence of Decedent 1 ☑ M 2 ☐ F 85 Harpersferry, WV 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Fairfax Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6258 Split Creek Lane 22312 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11 Mantal Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) P.G. County School Bus Driver School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Stoutsenberger Helen Conard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Director \$ Completed Be ပ

Physician

/Medical

Examiner

Funeral

Director

Leroy

10a. State

VA

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

ours after death.

neral Director: A
filled in by the fu

Division or Vital Records, P.O. Box 68760,

	Linda Adams (dau	ighter)	6258 Spli	t Creek Lane	Alexandr	ia, VA 22	2312	
	20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemovar nom State	ce of Disposition (Na netery, crematory or Lincoln	me of other place) Cemetery 3/2		rentwood,	· —	
	21. Signature of Funeral Service License	see	22. Name a 3401	nd Address of Facility \mathbf{F}_0 Bladensburg		n Funeral entwood,		
	23a. Part1. Enter the disease, or comp shock, or heart allure. List only of Immediate Cause (Final	one cause on each line.				t,	Approximate Interval Between Onset and Death	
	disease or condition resulting in death)	a. Ewb S Due to (or as a consequent	i A					
	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	equentially list conditions, any, leading to immediate ause. Linter Underlying ause (Disease or injury						
באם ובאם	resulting in death) Last	Due to (or as a consequent	nce of):					
i yaicidi // medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ectopic			23d. Date of de Month	l Blivery Day Year	
on Dy L	Part II. Other significant conditions co	ontributing to death but not resulti	ng in the underlying	cause given in Part I.			to the cause of death? Probably 4 □Unknown	
Complete					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of	
3	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)			
2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3 D	OA Other: 4 Nursing F	dome 5 ☐ Residen	ce 6 Other (Sp	ecify)	
	27. Manner of Death 1 ★ Partial 5 Pending 2 Accident investigation	(Month, Day Year)	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurre					
oci micano	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of injury - At home building, etc. (Specify)	e, farm, street, facto	et and Number or F State)	lural Route Number,			
calcal	29a. Certifier (Check only one) Check only one)	ysician: To the best of my knowle ilner: On the basis of examinatio and manner stated.	edge, death occurre n and/or investigation	d at the time, date and plac n, in my opinion, death occ	e, and due to the cau urred at the time, dat	se(s) and manner a e and place, and du	s stated. le to the cause(s)	
Ě	29b. Signature and title of certifier		25	c. License number	290	I. Date signed (Mon	th, Day, Year)	
		Bero, in		D00571	24	31180	08	
	20° Name and address of person who s	completed cause of death (Item C	20) (Type Drint)					

Registrar

T. Bao 31. Date filed (Month, Day, Year,

MAR 1 9 2008

Germantown, MD 20874

13219 Exective Park Terr.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02115 State of Maryland / Department of Health and Mental Hygiene Cindy X. Sorto-Reyes Certificate of Death 1- For State 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) 0041 hrs Physician/ March 16, 2008 Sorto-Reyes Medical Examiner Cindy Xiomara 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Greenhelt 5913 Cherrywood Terrace Apt. 201 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Foreign F1 Country Salvador 5. Social Security Number **Funeral** Hours Months 1988 27, 220-57-5387 19 Director 2 X F 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County any 10a State 1X Yes 2 No Greenbelt Prince Georges Md. 28a-f show or items 23a or 28a-f show must be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u> 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number El Salvador 20770 5913 Cherrywood Terrace 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married 2 Married 1 Yes 2 No specify: Salvadoran White Yes Specify If Yes. Give Year Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done \$ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Law Firm Secretary 9th Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Mercedes Reyes Guadulupe Sorto Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 77083 Houston, Texas 7314 Winkleman Road (Father Guadalupe Sorto 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 03/22/2008 20a. Method of Disposition crematory or other place 1 X Burial 2 Cremation 3 Removal from State Houston, Texas Forest Park Westheime Donation 5 Other Specify 22. Name and Address of Facility 23. Planted of Funeral Home, Inc.
3447 14th Street, N.W. Washington
23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death Medical a Multiple Gunshot Wounds Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical AMENDED UNPENDED attending physician or use as the burial 23d. Date of delivery The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 ✓ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? signed by the I be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ð 24b. Were autopsy findings available Completed 24a. Was an certificate has been s prior to completion of cause of autopsy performed? ✓ Yes 2 No death? 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Other₄ Be Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 Inpatient 2 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death After Subject was shot Certification: FOUND: 1 Yes 2 ✔ No Natural Pending Director: din by the f Mar 15, 2008 0032 hrs 28f. Location (Street and Number or Rural Route Number, City Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 5913 Cherrywood Terrace Apt. 201, Greenbelt, MD Could not be Suicide within 24 hours aft.

To the Funeral Di
completely filled in determined (Specify) Multi-Family Apt 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie March 16, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

State Registra

Pamela E. Southall, MD

MAR 1 9 2008

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mabe1 Solomon **Gladys** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Doctor's Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🕅 F Aug. 12, 1924 North Carolina 83 Director 578-30-0734 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at Yes 2 No Funeral Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20024 USA 1228 Howison Place, S.W. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√€ No Specify: Black 5-0036 Specify: Be Completed by 31 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Heaith and Mental Hygiene. Custodial Laborer Dept. of State is marked other 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Hannah Jones Moore Andrew Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Roslyn Perkins-Dranddaughter 13015 4th Street, Bowie, MD 20720 Department of Health Important: If item 27 any Injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MXBurial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'l Cemetery 3/24/08 Triangle, VA q 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licensee 3831 Georgia Ave., NW, Washington, DC 20011 278 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner certificate be executed physician and s the burial-trant Due to (or as a consequence of): Box 68760. Physician/Medical as attending p IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached for P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed ²24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has perform 25. Was case referre o medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ၉ within 24 hours after death.

To the Funeral Director: After this funeral 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 □ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

2008 Registrar



30 Name and address of person who completed cause of death (Item 23a) (Type, Print)



omon,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 2008 7:40 A M Simmons Mendelssohn Leon 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Allegany Frostburg Frostburg Village Nursing Home If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days 1 X M 2 □ F 83 236-20-9522 06/20/1924 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Cumberland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 13301 Winchester Road, SW, Lot V 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No 1945 — If Yes, Give Year or Dates: 1946 Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. Specify 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Я Conductor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ε. Shawver Simmons Mattie Samuel Glyspie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13709 Fir Tree Lane, Cresaptown, MD Sharon A. O'Neal / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Memorial Park 03/25/2008 | Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, 4 □ Donation 5 □ Other (Specify) Sunset Memorial Park 03/25/2008 21. Signature of Funeral Service License 21502 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 year ALZITE IMERS DEMENTIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9☐Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown avmar 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the 1 Department of Health and Mental Highan "natural", or items 23a or 28a-f any filing or other traumatic event, the Medical Examination of the property of other traumatic event, the Medical Examination of the property of the pro

Funeral Director

2

Completed

Be

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Examiner Physician/Medical þ Be Completed Certification: To

physician this filled in by Medical

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: 3+ nks RuiDB

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

29a. Certifier

(Check only one)

1 🔽 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide

Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year)

Injury

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

026907

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1□ Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Thelin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 Bishop Walsh Road, Cumberland, MD S. Sidhu, M.D., Harjit

31. Date filed (Month, Day, Year) MAR 2 5 2008

29b. Signature and title of certifier

3 Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Swartzwelder 0-2008 5:50PM Patricia Jean /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Cumberland 429 N. Centre Street 8. Date of Birth (Month, Day, Apr 25, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 ☐ F Μ̈́D Director 78 <u> 218-30-0676</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show mrit. If item 27 is marked other than "natural", or items 25a or 28a-f show mry or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Cumberland MD Allegany Y☐Yes 2☐No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 429 N. Centre Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed ★ ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rita Agnes Yarnall Stegmaier Maurice Michael Stegmaier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other trai once. Shelley Welsh P.O. Box 883 Cumberland daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 3/27/2008 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Los Asia 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ukemi days-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed y physician and as the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending | | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 ☐ Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 Vo 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient this 27. Manny r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After i etely filled in by the funera 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadway 4 STURNING CHANGE M.D 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	te of Maryland	-	artment of F ctificate of		Mental Hy			
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate or	Deau	2. Date of De		3. Time of Bealt	30
	Physici /Medi		EDITH M. CL	IPPER STE	WART			MÄRCH	1^{17} , 20°	08 11:36F	M
	Examir	er-	4a. Facility Name (If not institution, give street a 9511 Stewartown			4b. City, Town, o	or Location of De nersbur		4c. County of	Death GOMERY	
مدا	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		rs. 8 Date of Bir	th C	Birthplace (State or Fore	∍ign
	Director		218-30-6797 1 M 2 Usual Residence of Decedent	81	Yrs.	Monaro Bayo	Tiodis III	Mar.1	iy, Year) 4,1927	Maryland	
	yland how at		10a. State 10b. County		, Town or Lo					10d. Inside City Lim	nits
	he Ma 8a-f s	Director	MD Montgomer	ТУ	Ga	ithersh	ourg			1 □ Yes % □	No
	and the man		10e. Street and Number 9511 Stewartown	Road		10f. Zip Code	20879		10g. Citizen of Wh	at Country?	
	death	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S	S. 13. V			(Specify Yes or No erto Rican, etc.)		American Indian,	
36	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married]Yes 2 X No es, Give ar or Dates:		l □Yes 2½TNo	Specify:	erio nicari, etc.)		White, etc. Black	
21215-0036	2 hour latural		15. Decedent's Education		16a. Deced	lent's Usual Occup	oation		16b. Kind of Busin	ness/Industry	
21	within 7 iene. than "r	Completed		lege (1-4or 5+)		kind of work done	•	rorking	77		
d 21	filed with! Hygiene. Ither than		10th 17. Father's Name (First, Middle, Last)		n	ousewif		ame (First, Middle	Home , Maiden Surname)		
/lan	2 should be and Mental Is marked o aumatic eve	To Be	Bose Clipper					sa Wats	,		
Maryland	l 2 sho h and l ls ma rauma	i ,	19a. Informant's Name/Relationship (Type. Pri. Richard Stewart (E		f				er, City or Town, St	ate, Zip Code) rg, MD 208	70
	Healt Healt tem 27	3	20a. Method of Disposition	20b. PI	ace of Dispos	sition (Name of	i	Date Date	20c. Location - Ci		<i></i>
mo	Pages nent of int: If i		1X Burial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (<i>Specify</i>)			natorý or other pla Grove C		21/08		ville,MD	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ment Important: If item 27 Is marked any Injury or other traumatic e once.		21. Signature of Funeral Service Licensee	Lucus						L HOME,P.A le,MD 2085	
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death se on each line.	. Do not ente	er the mode of dyin	ng, such as card	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer									ıs
	Examiner			ue to (or as a consequ	ence or):						
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase of liquity that initiated events C								
,	execution and al-tran	Examine	that initiated events resulting in death) Last	ue to (or as a consequ	ence of):						
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Box	death certifi e attending d for use as	Physician/M	in the past 12 months?	es, outcome pf pregnar]Live birth 2☐ Fetal]Pregnant at time of de	death 3	Ectopic pregnanc	у		23d. Date of Month	*	
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or Vital Records,	The law rate has be page 2 sh	Completed						24a. Was auto perfo	psy prid prmed? dea	ere autopsy findings availa or to completion of cause of ath? Yes 2 \(\square\) No	ble of
Vita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner? 1 Types 27 No. Hospital			I ou		eath (Check only o			
ō	ding Physician: The	- To	TE TES ZANO	Date of Injury	R/Outpatient 28b. Time of		4 ⊔ Nursing		dence 6 Other	. , ., .,	
ion	ath. ath. r: After re funer	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2 ∐ No		,		
Division	tal or Atte s after de al Directo	Certification:	3 Suicide 6 Could not be determined 28e.	Place of injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only one) 1 ☑ Certifying Physician: 2 ☐ Medical Examiner: On an	To the best of my know the basis of examinati manner stated.	vledge, death on and/or inv	occurred at the til restigation, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)	
	Tot with Tot	Σ	29b. Signature and title of certifier			29c. Licens	45880		29d. Date signed (//	* * * * * * * * * * * * * * * * * * * *	
	4		30. Name and address of person who complete Leon C. Hwang, M.				ive, R	ockvill	e, MD 2	20850	
150	Sta Registr	te ar	31. Date filed (Month, Pay, Year) MAR 2 0 2008	32. Resistrar's Signatu	lre	aget)					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** 12:00 P M Louis Schloss March 14, Allen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery 16804 George Washington Drive If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe 6. Sex **Funeral** Months Days Hours 1**X** M 2□F Director 63 102-36-3404 Mar. 14,1945 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 USA 16804 George Washington Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1966— 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Affiled Folces: 1)X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 ☐ Widowed 4 ☐ Divorced White "natural" 1970 Completed permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Insurance Holding Elementary/Secondary (0-12) College (1-4or 5+) Computer Programer Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucille Kreyer ပ Henry Schloss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16804 George Washington Drive Rockville, MD 20853 Essie A. Schloss/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State March 18, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 2008 Olney, Maryland 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License a 10 East Park Drive Gaithersburg, MD 20877 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Metastatic Melanoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician as the burial-1 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Testicular Cancer 2K No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate ha autopsy perform 1☐ Yes 2☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ၉ 1 Yes 2 No 1 🖺 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:.
completely filled in by the t 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760, the Hospital

20+1

Harminder S. Sethi, M.D., 1140 Varnum Street, N.E., Washington, DC 20017 31. Date filed (Month Aar) State 2008 Registrar

29b. Signature and title of certifier

(Check : ily



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D52767

29d. Date signed (Month, Day, Year)

March 17, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** P^{M} KARI BAKKE STAMBERG MARCH 20 2008 55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE NURSING CENTER ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Day, NOV 9 Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours 1 M 2 M F Min. 94 214-76-8361 1913 NORWAY Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r 28a-f show notified at show 1 ☐ Yes 2 No MD MONTGOMERY SILVER SPRING Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 2 lner must be n 611 WINONA COURT 20901 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iten 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KARL BAKKE OLGA OLSEN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DAUGHTER-IN-LAW ELENA STAMBERG/ P.O. BOX 379, BARNESVILLE, MD 20838 20b. Place of Disposition (Name of cemetery, crematory or other p 20a Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot COLESVILLE CEMET. 1 X Burial 2 □ Cremation 3 □ Removal from State 3/29/08 COLESVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNES 21. Signature of Fune al Service Ligenses BARNESVILLE. 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed PARKINSON'S DISEASE as the burial-trans Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? for Month Day 5 ☐ Other (specify) ed by the a detached for 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed?

1 Yes 2 No 2∏No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0047330 3/20/08 Joseph Swownys 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS JOSEPH, 50 W. EDMONSTON DR., #207, ROCKVILLE, MD MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 4 2008 > Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 0 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 ĭ°9 DONALD ALAN SCHAEFFER MARCH 10:10PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY 17244 SPATES HILL ROAD POOLESVILLE 8. Date of Birth (Month, Day, Yea APR . 10 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Year) 1**X**M 2□ F Director 301-22-0272 80 Usual Residence of Decedent permit. Pages 1 and 2 st ould be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 271 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No MONTGOMERY POOLESVILLE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19921 WESTERLY AVE. 20837 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 📉 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 1954 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) COMMERCIAL Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION SUPERINTENDENT CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RAYMOND SCHAEFFER VERA CATHERINE RICHARDS ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANNE SCHAEFFER/SPOUSE 19921 WESTERLY AVE., POOLESVILLE, MD 20837 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) TRINITY CHURCH 1 Burial 2 □ Cremation 3 □ Removal from State 3/24/08 PRINCE FREDERICK 4 Donation 5 Dother (Specify) CEMETERY 21. Signature of Fundal e vice license 22. Name and Address of Facility HILTON FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20838 BARNESVILLE. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consec quence of) Examiner the death certificate be executed physician and s the bunal-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant condit ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performe certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) DAUGHTERS 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ۴ funeral HOUSE 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident M 1 TYes 2 □ No. death. within 24 hours after death To the Funeral Director... 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

0

State Registrar

29b. Signature and the of certifier

31. Date filed (Month, Day, Year)

Ahmad Heshmat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 4 2008

MD

32. Registras Signature

DHMH 17 Rev 1/2001

9715 Medical Center, IR.

29c. License number

#201

29d. Date signed (Month, Day, Year)

MARCH 21, 2008

RECKVITE MID

08-02265 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gregory P Schoonover State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3-Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Year Medical Examiner 1229 hrs March 22, 2008 Gregory Patrick Schoonover 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Caroline 6073 Picture Hill Drive Prestor 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 6. Sex Foreign Months Hours Director Country) Maryland 1996 215-47-9165 May 20, 1 XM 2 F 11 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Preston Caroline Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6073 Picture Hill Drive 21655 United States of America Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 4 Divorced If Yes, Give Year Yes 2 No specify: Specify: Caucasian Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) MD 21215-0036 Middle School Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Schoonover Becky Sue Quillen Joseph Patrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6073 Picture Hill DRive, Preston, Maryland 21655 Joseph P. Schoonover Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Denton Cemetery 3/28/2008 Denton, Maryland Other Specify: Noore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 21. Signature of Funeral Service Licenses JOIDUT 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical attending physician a UNPENDED AMENDED of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Dav icate has been signed by the attending page 2 should be detached for use as Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 V Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medica Be examiner? Hospital: Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes No 28a. Date of Injury (Month, Day Year) Mar 22, 2008 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Driver of ATV impact with fixed object 1210 hrs Division Natural 1 Yes 2 ✔ No Pending completely filled in by the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 6073 Picture Hill Drive, Preston, MD determined (Specify) Single Family Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29d. Date signed (Month, Day, Year) 294 29c. License number O.C.M.E. March 23, 2008 Myone 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Margarita Korell MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month 200832. Re ar's Signature State Registrar OCME DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items par fb 879 5-21 08 lytand Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1113PM SUTHERLAND 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner City Baltmore THE JOHNS HOSPITAL HOPKINS If Under 1 Year I ff Under 24 Hrs. Min. Months Days Hours Min. May 3, 194 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 1**X**XM 2 ☐ F 5. S21°7°92′-9092 **Funeral** 1949 England Director Usuat Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County -how 1 Yes 2 No ir than "natural", or iteme 23a or 28a-f ehov the Medical Examinar must be nutified at Be Completed by Funeral Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23a any injury or other traumatic event, the Madical Examinat must once. 996 Moss Haven Court 21403 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TVNo If Yes, Give XXX Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) 4 Entrepreneur Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Owen Ivan B. Sutherland ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, Maryland 21403 996 Moss Haven Court Bonna J. Sutherland / 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory 3/20/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Michel 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Dre month Physician Leukemia /Medical Due to (or as a consequence of): **Examiner** Tumov lusis Sequentially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner physicien end s the burial-transit The law requires that the death certificate be executed (varulation I Scular issemi te Due to (or as a consequence of) Records, P.O. Box 68760. attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed I Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes Division of Vital Fo the Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire filled in Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 245-000 March 18,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aloigail Lenhart The Johns Hopkins Hospital GOON WOLFG ST Baltimore MD 21287 32. Pigistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Leonard 24 2008 9:05 Charles Sanders March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17539 Gay Street Hagerstown Washington Sex 1X M 2□F If Under Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 9. Birthplac (State or Foreign Social Security Number Funeral Days Hours Months Yrs 723-18-3372 79 June 4, 1928 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a 17539 Gay Street USA Race - American Indian Black, White, etc. 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married 1 ☐ Yes 2X If Yes, Give Year or Dates: 1□Yes ≱ No Baltimore, Maryland 21215-0036 Specify. þ within 72 hours 3 Widowed 4 Divorced White 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Engineer Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပို Preston Sanders Bertie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17539 Gay St. Hagerstown, Mary Land ace of Disposition (Name of Date 20c. Locat Barbara J. Sanders - Wife 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages: Department of H Important: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or 4 Donation 5 Other (Specify) Mar.27.2008 Williamsport, Maryland Greenlawn Mem. Park 21. Si y atur Storned from er Erilly Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner death certificate be executed end Due to (or as a consequence of): ettending physician e for use as the burial-Box 68760. Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the e P.O. I ☐Yes 2☐No 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown has been significant to the second of the se 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page After this certificate 1□ Yes 21 No Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 2 Accident within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number

State

Registrar

5 2

08-02369	
Anita Sharpe	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Anita Snarpe		State of Maryland / Department of Health and Merital For State Certificate of Death		g. No. 200	8 1103
Physiciar	1/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	n Dav Year	3. Time of Death 1721 hrs
Medical Examin		ANITA SHARPE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	March 25,	2008 4c. County of Death	1/211115
		Washington Adventist Hospital Takoma Park		Montgomery	
Funeral Director	- 1	5. Social Security Number 5.77-38-7558 1 M 2 TF 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24Hr Months Days Hours Min		h(MM/DD/YYYY) 9. Birt Foreig 1928 Cor	MASHINGTON
any		Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County			10d. Inside City Limits
≥	١,	MD PRINCE GEORGES HYATTSVILLE			1XXX Yes 2 No
Maryla	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
vith the		5418 GALLATIN STREET 20781 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$)		USA 14. Race - Ameri	can Indian, Black,
r items	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerl		White, etc.	CV
s after ral", o	ਣ∤	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	f work done	Specify: BLA	
72 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			.
0036 within iene.	팂	12TH CLERK	me (First, Middle, N	PRIVATE	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	The delication of the state of	MAE WOO		
212 nould be d Ment is mark	입	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	r Rural Route Num	ber, City or Town, State	
, MD and 2 sho ealth and em 27 is raumati	-	GLORIA A. WALKER/SISTER 1243 NEWTON ST. N.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	WASHING' Date	TON, DC 200 20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		Crematory or other place)	/04/2008	LANDOVER,	MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. 7474 LANDOVER ROA			
Physician		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Hemorrhage complicating sacral of	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		Immediate Cause (Final disease or condition resulting in death) a. debridement procedure Due to (or as a consequence of):			Death
,		Sequentially list conditions, b.			
	iner	if any, leading to immediate Duc to (or as a consequence of). cause. Enter Underlying Cause			
ted 1 Insit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
be execuician and	dical	X UNPENDED AMENDED 23a, PII, 27, 28a-f, perME, g881	7/31/08		
, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and the detached for use as the burial - transit.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy	23d. Date of deliver	y Day Year
Bo he deat y the at the for	hys	1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
P.O es that t	ত্র	Hypertensive atherosclerotic cardiovascular disea			bably 4 🗸 Unknown
ords aw requinas been 2 should	Completed	diabetes mellitus, history of breast cancer	24a. Was autop	psy prior to death?	utopsy findings available completion of cause of
Vital Rec ysician: The l his certificate l director, page	o l	25. Was case referred to medical 26.Place of Death (Chec			
F Vit. Physici rr this c	To B	1 Yes 2 No	rsing Home 5	Residence 6 Other	
onding and the funer	ë	1 Natural 5 Pending 3/25/2008 10.30 am 1 Yes 2 X No	procedu		debridement
Visic or Atter ter dea Mrector	ficat	2 X Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R	ural Route Number, City
Div Spital of nours af filled i	Certification:	4 Homicide determined (Specify) Nursing home			on Adventist
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as sta and place, and due to t	ted. he cause(s)
To To Con	Mec	and manner stated.	CME	29d. Date signed (M	onth, Day, Year)
		Theody M. Kit & Thy O.C.M.E.		March 27, 2008	
		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltime	ore, MD 2120	1	
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Regist		4 0000 F W #ABAR /			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Μ. Thomas March 13, 2008 /Medical Lawrence 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George's If Under 1 Year Social Security Number '. Age (In yrs. last birthday) Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**∑**M 2□F Months Hours Yrs Director 216-30-4363 Oct. 10, 1933 | Washington, DC 74 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at YEYes 2□No Directo Maryland| Prince George's Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or Funeral 500 North Harry Truman Drive 20774 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1√ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** Hygiene. other than "natur ent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental P ont of Health and Mental t: If item 27 Is marked o y or other traumatic eve Pages 1 and 2 should Daniel A. Thomas, Sr. Dorothy E. Snowden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores A. Thomas - Sister 2513 Millvale Avenue Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State P Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet's Cemetery Mar 19, 2008 Cheltenham, MD 21. Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a possequence of V **Physiclan** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

To the Hospital of within 24 hours at To the Funeral D

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Gary

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 9 2008

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

3001

HOSPITAI

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many or stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 MANJEH AGNES TONYA Tiorer /Medical 4c. county of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** DOCTORS HOSPITAL LANHAM PRINCE GEORGES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 04/16/1947 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □**X**F Director 227-79-5802 60 LIMBE, CAMEROON Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 No Funeral Director PRINCE GEORGES LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Maryland 21215-0036 item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 6425 TIFFANY COURT 20706 WEST AFRICA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. þ Specify: BLACK 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If item 27 is marked ott any injury or other traumatic ever MBE TAKU EKONJAH TAKU 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILFRED A. TAKU/NEPHEW 6425 TIFFANY COURT LANHAM, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MENJI CEMETERY 04/07/2008 MENJI, FONTEM 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL ROME 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. led by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 icate has been sig , page 2 should b Completed 1 ☐ Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an certificate has autopsy 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[No 1 TYes 1 Inpatient P 2 ☐ ER/Outpatient 3□ DOA Manner of Death 28a. Date of Injury 28b. Time of Certification: 28d. Describe how injury occurred or Attending 1 Natural
2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8/18 Good LuckRd., Lanham, MD. 20706 Thomas a

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 9 2008

32. Registrar's Signature

15 Sports

			1 - For State Registrar	State of Marylan		artment of			giene		11040	
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month			3. Time of Death	
	Physici /Medio		HERMAN	TAYL	OR			MARCH		2008	11:59 P M	
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Dea	ath	4c.	County of Death		
			1203 Holton Lane			Takoma				ntgomery		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 89	last birthday) Yrs.	Months Days	r If Under 24 Hr Hours Mir	. (Month, Day	y, Year)	Cou	place (State or Foreign ntry)	
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	land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
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	r 288	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	ntry?	
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	be filed within 72 hours after deeth with the Maryland ital Hygiene. d other than "natural", or iteme 23a or 28a-f show event, it a Medical Examinar must be notified at	Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No-	.	14. Race - Ameri		
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2	should and Men amarke umatic	2	19a. Informant's Name/Relationship (Typ	ne Print)	19h Mailir	na Address /Stree		Rural Route Numbe		r Town State 7	n Code)	
<u>8</u>	d 2 s th ar th ar trau	11	Garcille M. Taylor	(Wife)				koma Park	-		0 0000)	
စ်	les 1 and 2 should be filed w of Health and Mental Hygier of Item 27 is marked other the other traumatic event, Item		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of	!	Date		cation - City or T	own, State	
٥	Peges nent of int: If It iry or o	- 5	1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movai from State	-	natory`or other pl		19/2008	Bros	ntwood.	MD	
Baltimore,			21. Signature of Funeral Service Cense					rt Lincol				
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VII	ysician: Th is certiticate director, pag	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Check only or	nel			
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	- 5 - 0		> Somlea Pane	Noy MD		MD#	D0058627			Н 13, 2		
	4	}	30. Name and address of person who con		1 23a) (Type	Print)						
	110		SONIKA PANDEY, M.D	., VA MEDICAI	CENTI		RVING ST	REET NW,	WASE	INGTON,	DC 20422	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	مناسلا							

		1 _ State	partment of Health and N	∕lental Hygie	ne								
-		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg.	No. 2008 3 time of Peath								
Physic		James Taylor		Month	Day Year 2008 3:10 PM								
/Med Exam		4a. Fadility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death								
	₽	Woodside Center	Silver Spring		Montgomery								
Funera	•	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, Ye									
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or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?								
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ter de item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ₩ Married 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	14. Race - American Indian, Black, White, etc.								
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shou and M s mar umati	-		ailing Address (Street and Number or Ru		ity or Town, State, Zip Code)								
and 2 saith a 27 is	d.	Kimberly Taylor Logan/Daughter 74	5 Park Road N.W. W	ashington	DC 20010								
of He		20a. Method of Disposition 20b. Place of D cemetery, 3 □ Removal from State	sposition (Name of crematory or other place)	Date 200	c. Location - City or Town, State								
. Pag tment tant:	1	4□Donation 5□Other(Specify) Fort Li			centwood, MD.								
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fulleral Service Licensee	22. Name and Address of Facility Mcc 7400 Georgia Ave.,	Guire Fune NW Washir	eral Service, Inc.								
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death								
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The law requires that the death certific the has been signed by the attending page 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant 23c. If yes, outcome pr pregnancy 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year								
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or Attending Physician: ifter death. Director: After this certifical in by the funeral director, i	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 1 ☑ Natural 5 ☐ Pending (Month, Day Year)		28d. Describe how	injury occurred								
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al or /	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)								
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one) 176 Certifying Physician: To the best of my knowledge, companies to the desired physician of the desired physicia	to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a manner stated.										
To the within To the comp	M	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)								
4(1-VA)		Scuma Change, A 30. Name and address of person who completed cause of death (Item 23a) (Ty		Ma	arch 14, 2008								
		Saima U. Khawaja, M.D. 11119 Rock	ville Pike Ste 100	Rockvill	e. MD. 20852								
	tate	31. Date filed (Month, Day, Year) MAR 2 1 2008 32. Ingistrar's Signature											
Regis	uar	July 1	Jane Land										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month 3 2008 Physician 7:25 A M Arthur Tatum /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Worcester Ocean City 12640 Balte Rd. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Pay Year) 12/21/1923 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F 84 194-18-9052 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Worcester Ocean City Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21842 12640 Balte Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 and Mental Hygiene.
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Department of He
Important: If item
any injury or oth 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/21/2008 Frankford, DE Cape Henlopen Crem. 4 Donation 5 Other (Specify) The Burbage Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service License 108 William St., Berlin. MD 21811 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metastatic mo. Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the huria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Day Month in the past 12 months? 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ wnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely f 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Merch 21 2008 D0014314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E Coull Stret, Solis bury, MD KLVa.

State
Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

y sparke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State AMEND#5perFH3-24		Cer	tificate of D	eath	Re	g. No. C U U U	11040	
70.	Physici /Medic		Decedent's Name (First, Middle, Last)	Jeanette		TAUGE	R	2. Date of Death Month March 20	Day Year	3. Time of Death 11:50 A м	
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or I	ocation of Death	1147 417	4c. County of Dear	th	
			Arcola Health Care	e Center		Silve	r Spring		Montgom	ery	
	Funeral		5 1 S 3 c 3 Se 0 u rt y-N 1m1 e 6 1 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bin	thplace (State or Foreign ountry)	
	Director			5 X 1, 00	Yrs.			March 3	1, 1921 N	lew York	
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits	
	Maryl F sho ed al	ō	Maryland Montgo	omerv	Potom	a.c.				1 □Yes 2 No	
	the P	Director	10e. Street and Number	5		10f. Zip Code		10	g. Citizen of What Co	buntry?	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 23a-f show ent, the Medical Examiner must be notified at	ral Di	7937 Sandalfoot Dr	ive			20854		United St	ates	
	tems tems	Funeral	T. Martar States	Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His f Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	I□Yes 2√∏No	Specify:		Specify: Wh	ite	
21215-0036	thou atural	edt	15. Decedent's Educ	ation	16a. Decedent's Usual Occupation			1	6b. Kind of Business	/Industry	
715	nin 72 .n "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done du DO NOT use retired)	ıring most of worki	ng			
212	d with giene sr tha the	ĕ	12	0011090 (1 401 01)	Н	omemaker			Own Home		
Maryland	e d tal	Be	17. Father's Name (<i>First, Middle, Last</i>)	harles Rosenzw	eig		18. Mother's Name Saral	n Barkin Barkin	aiden Surname)		
$\overline{\leq}$	should ind Men marke umatic	욘	19a, Informant's Name/Relationship (Typ	ne. Print)	19b. Mailin	ng Address (Street a	nd Number or Rura	al Route Number,	City or Town, State, .	Zip Code)	
	and 2 ealth a n 27 is		Ellen Goldberg, Dag	ughter	7937	Sandalfoo	t Drive,	Potomac	, MD 2085	54	
Je,	of Her		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other place	,	Date 2	0c. Location - City or	Town, State	
Ĕ	2 P E C C		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State		d Cemeter	1	3/08 1	Elmont, NY	,	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		21. Signature Fune 1 2 parca Licens		lT o	Name and Address	Hobrau Er	meral H	nme		
ш	20 E # 5		23a. Part 1. Enter the disease, or complication for heart failure. List only on		25	4 Carroll	St., NW	. Washin	g ton, DC	20012	
2			23a. Part1. Eater the disease, or complic shock, or heart failure. List only on	cations that caused the death. e cause on each line.	Do not ent	er the mode of dying	, such as cardiac o	or respiratory arre	St,	Approximate Interval Between Onset and Death	
8	Physician		Immediate Cause (Final disease or condition resulting in death)	Alzheimer'						years	
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):						
		-E	Sequentially list conditions, b.	Due to for as a consulue	ence of):						
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	exec in and rial-tra	Еха	resulting in death) Last	Due to (or as a conseque	ence of):						
68760,	ficate be executed physician and is the burial-transit	edical	d								
			IF FEMALE:								
Вох	death certifii attending p I for use as	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnand 1 ☐ Live birth 2 ☐ Fetal o	death 3		livery Day Year				
0	he dei the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5∟	Other (specify)			Month	,	
P.0.	that the		Part II. Other significant conditions con	tributing to death but not result	ing in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute t	o the cause of death?	
ds,	The law requires that the death cert te has been signed by the attending age 2 should be detached for use	d by						1 ☐ Ye	s XX No 3 □ P	robably 4 □Unknown	
-	aw re s bee	ete									
SCOL		~						24a. Was an		utopsy findings available	
Recor	The lay	dmo						autopsy	/ prior to	completion of cause of	
ital Recor	ian: The lantificate hastor, page 3	3e Completed	25. Was case referred to medical				26. Place of Death	autopsy perform 1∐ Yes 2	/ prior to death? Large 1 □ Yes	utopsy findings available completion of cause of s 2 □ No	
r Vital Records,	nysician: The L his certificate ha director, page 3	Be	examiner?	ospital: 1 □ Inpatient 2 □ E	R/Outpatien	ıt 3□ DOA Othe	r-	autopsy perform 1□ Yes 2	/ prior to death? Large 1 □ Yes	completion of cause of 3 2 □ No	
n or Vital Recor	ng Physician: The l ifter this certificate ha ineral director, page i	To Be	examiner? 1 Yes 2 No 27. Manner of Death	1 Inpatient 2 E	R/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 Nursing Ho at ?	autopsy perform 1□ Yes 2	prior to death? No 1 Yes	completion of cause of 3 2 □ No	
sion or Vital Recor	tending Physician: The leath. tor: After this certificate ha the funeral director, page?	To Be	examiner? 1 Yes 2 No 27. Manner of Death 12 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work' M 1 Y	r: 4⊠ Nursing Ho at ? es 2□No	autops) perform 1 Yes 2 n (Check only one me 5 Resider 28d. Describe how	y prior to death? 1 No 1 Yes y) noce 6 □Other (Spewinjury occurred	completion of cause of a 2 No	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **JAMES** 24 M LLOYD 03 2008 TWIGG 1610 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death WMHS - MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1)**∑** M 2 □ F 86 216-14-1659 11/20/1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1¶ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1803 Bedford Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No 1942 – If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify: Specify 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communication Dispatcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DeNenna Theodore Twigg 0ko McElfish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Lower E. Valley Road, Dunlap, TN John T. Twigg/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Vet Cem @ Rocky Gap 03/27/2008 em @ Rocky Gap 03/27/2008 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Skinature of Funeral Service License 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGESTIVE

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Director

Funeral

ģ

Completed

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit signed by the a d be detached f

After thi funeral of

Division or Vital Records, P.O. Box 68760,

Completed by Physician/Medical Be ٩ Certification:

death certificate be executed To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the f

3 nos

> State Registrar

29b. Signature and title of certifier

MARILYN NGLSON

MAR 2 6 2008

31. Date filed (Month, Day, Year)

	Tooding in doding	Due to (or as a consequen-	ce of):				
7	Sequentially list conditions,	b. INOPERABLE		ceis			
ical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CAD Due to (or as a consequent					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐ Ectopic			23d. Date of delive Month	ry Day Year
ed by Pr	Part II. Other significant conditions of	contributing to death but not resultin	g in the underlying	cause given in Part I.		use contribute to th	
Complet	RENAL FAILUR	€			24a. Was an autopsy performed? 1∐ Yes 21 ∑ No	prior to con death?	osy findings available npletion of cause of 2 No
Be	25. Was case referred to medical			26. Place of De	ath (Check only one)		
10E	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ER/	Outpatient 3 ☐ □	Other: 4 Nursing I	Home 5 ☐ Residence	6 □Other (Specify	′)
	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred	
Sertific	3 ☐ Suicide 6 ☐ Could not b. 4 ☐ Homicide determined		, farm, street, facto	ry, office	office 28f. Location (Street and Number or Rural Route Numb City or Town, State)		
Medical Certification:	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurre and/or investigation	d at the time, date and plac on, in my opinion, death occ	e, and due to the cause(s urred at the time, date an	s) and manner as st nd place, and due to	ated. the cause(s)
Me	29h Signature and title of certifier		2	9c. License number	29d Da	ate signed (Month)	Day Year)

29c. License number

D0065518

621 Kelly Rd, Cumberland MD 21502

29d. Date signed (Month, Day, Year)

3/25/08

DHMH 17 Rev 1/2001

MK Welson

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Chaves lane The	The of the black indensite link. Linsuite All Copies Are E
Sharon Jane Thomas	State of Maryland / Department of Health and Mantal Liveiana
4 Fan Ctat	State of Maryland / Department of Health and Mental Hygiene

		1- For State Ce	rtificate of Death		g. No. 200	8 1104					
Physic al Exaπ			T1	2. Date of Death	1	3. Time of Death					
		4a. Facility Name (if not institution, give street and number)	Thomas 4b. City, Town, or Location	Month March 18, 2		1134 hrs					
		16 Queen City Pavement, 3rd Floor	Cumberland	or Death	4c. County of Death Allegany						
Funera		5. Social Security Number 6. Sex 7. Age (In yrs.		ler 24Hrs. 8. Date of Birth	f Birth (MM/DD/YYYY) 9. Birthplace (State or						
Director		215-44-7748 1_M 2\lambda f 62	Yrs. Months Days Hour	s Min. 01/31/	Foreign Maryland Country						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location								
	_	MD Allowans	Cumberland		1	10d. Inside City Limits 1 XYes 2 No					
farylar 28a-f s at on	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Countr						
vith the Maryland s 23a or 28a-f show a	ä	16 Queen City Pavement, 3rd Fl	.oor 215		USA	,					
th with ems 2.	1 6	11. Marital Status 12. Was Decedent Ever in U	.S. 13. Was Decedent of Hispanic On	igin? (Specify Yes or No-	14. Race - America	an Indian, Black,					
er dea	Fun	1 Yes 2 No	If Yes, specify Cuban, Mexican		White, etc.						
urs afl tural' aming	d by	3 Widowed 4 X Divorced ff Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify:		Specify: Wh	ite					
6 72 ho un "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT	use retired)							
5-0036 led within 72 Hygiene. other than the Medical	l E	12	Laborer		Manufactu	ring					
21215-003 uld be filed withi Mental Hygiene, marked other th	Be C	17. Father's Name (First, Middle, Last) Leonard Wayne		r's Name (First, Middle, M bel		V . 3.3					
D 21215-0036 should be filed within 72 hours after death with the Maryland and Merial Hygerer is a fired within 1°2 hours after death with the Maryland is marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once	To B	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Nun		Margaret	Kelly					
5 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4		James A. Thomas / Brother	1001 E. Oldtown R			1502					
# E E E E		20a. Method of Disposition 20b. 1 Burial 2 X Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or To	• -					
LimC Page ment tant: or ot		4 Donation 5 Other Specify: Cu	mberland Crematory	03/21/2008	Cumberland	dw i					
Baltimore permit. Pages 1 Department of H Important: If i		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	y Adams Famil	ly Funeral H	Home, P.A.					
Physician		23a. Fart I. Enter the disease, or complications that caused the death	I 404 Decatur S	treet Cumbe	anland MD	21502					
Medical		randre. List only one cause on each line.		ardiac or respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death					
_xammer	_xaminer Immediate Cause (Final disease or condition resulting in death) Immediate (Final di										
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	Cause. Enter Underlying Cause (Disease or injury that initiated c										
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Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED									
760, frate be g physici the buri		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the	nancy		23d. Date of delivery						
Box 68 certification and for use as t	Physician	past 12 months?	ath	cpregnancy	Month Day	y Year					
BO te deat the att	hysi	1 Yes 2 No 9 V Unknown 9 Unknown	5 Other (Specify)								
P.O. ss that the gned by e detache	by P	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Pa	art I. 23e. Did tob	acco use contribute to the	e cause of death?					
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of Vital Records, ag Physician: The law require this certificate has been simeral director, page 2 should be	Completed			24a. Was an autopsy	prior to con	osy findings available inpletion of cause of					
tal Rection: The		25. Was case referred to medical		perform 1 ✓ Yes 2	ed? death? No 1 Yes	2 No					
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sion trendi death.	atio	1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2	No							
Division spital or Attenditions after death. Teral Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At no	me, farm, street, factory, office building, etc	c. 28f. Location (Str or Town, Star	eet and Number or Rural	Route Number, City					
F 2 5 E		4 Homicide determined (Specify) 29a. Certifier									
To the Ho within 24 t To the Fur completely	Medical	Certifying Physician: To the best of my knowledg one) 2 Medical Examiner: On the basis of examination and and money set set with the basis of examination and and money set set with the basis of examination and and money set with the basis of examination and the basis of exami	 e, death occurred at the time, date and plant d/or investigation, in my opinion, death occ 	ce, and due to the cause(s) and manner as stated. If place, and due to the c	ause(s)					
To To com	₩.	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month)						
2		Carde Hallan	O.C.M.E.		March 19, 2008						
		30. Name and address of person who completed cause of death (Item:									
MAS	ate	Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month Par Year) 32. Regulars's Signatur	111 Penn Street, Baltimore, MD	21201							
Regist	rar	31. Date filed (Month, Day Year) 1 2008 32. Regulars's Signatur	K hack								

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Physician /Medical **Examiner** 5. Social Security Number **Funeral** 219-26-8248 Director Usual Residence of Decedent 10b. County show Director 28a-f 10e. Street and Number 23a or "natural", or items 23a Funeral 11. Marital Status 1 ☐ Never Married 2 ☐ Married TYRE, JEAN Itimore, Maryland 21215-0036 \$ 3 X Widowed 4 ☐ Divorced Completed Elementary/Secondary (0-12) than permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) Be CLYDE QUIGLEY ဥ 20a. Method of Disposition 21. Signature of Funeral Service Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trai attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2 ☑ No 1 ☐ Yes 9 Unknown δ

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JEAN QUIGLEY TYRE MARCH 21 5:30A 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) WORCESTER BERLIN NURSING HOME BERLIN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-21-1932 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 ☐ M 2 💢 F Yrs. 75 DELAWARE 10d. Inside City Limits 10c. City, Town or Location 1X Yes 2 □ No MARYLAND WORCESTER BERLIN 10g. Citizen of What Country? 10f. Zip Code 9715 HEALTHWAY DRIVE 21811 US 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 □ Yes 2X No WHITE Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) HOMEMAKER NONE 18. Mother's Name (First, Middle, Maiden Surname) HELEN PALMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JEANNE L. HOOPER/ DAUGHTER 10048 BISHOPVILLE RD, BISHOPVILLE, MD. 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State ST. GEORGE'S CEMETERY 3-24-08 CLARKSVILLE, DELAWARE 22. Name and Address of Facility
MELSON FUNERAL SERVICES, LTD.
43 THATCHER ST, FRANKFORD, DELAWARE. 19945 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line. Approximate Interval Between Onset and Death Atheroselectic Cardiovascular trees -Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Discuse 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide [🖒 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number me and eddress of person who completed cause of death (Item 23a) (Type, Print) Coastal Haghway 1257 Registrar's Signature 31. Date filed (Month, Day, Year) 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Completed e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifice Be P Certification: Funeral Directo etely filled in by t Medical To the Faviet Island, De 1994 State MAR 2 4 Registrar DHMH 17 Rev 1/2001 ORIGINAL

	1	For State of Maryland State Registrar	•	tment of He ificate of E			-200	8 1104			
	1.	Registrar Decedent's Name (First, Middle, Last)	Och	meate of E	Call	2. Date of Death	. No. <u> </u>	3. Time of Death			
ian cal	ı	William James Tibbitt				March	Day ZZ Ze	ta 1145 ™			
ner		a. Facility Name (If not institution, give street and number)	I .	4b. City, Town, or			4c. County of D				
100		Memorial Hospital at East		Eash If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Talbo				
	L	. Social Security Number 6. Sex 7. Age (In yrs. lass 215–26–2587 1 M 2 □ F 78		Months Days	Hours Min.	Oct 25 19	29 Ma	Birthplace (State or Foreig Country) ryland			
tor		M 1 1 0 1.	own or Loca nton	ation	***************************************			10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
Director		0e. Street and Number		10f. Zip Code			. Citizen of What	Country?			
ra	\vdash	24760 Logans Woods Drive	T	2162			USA				
by Funeral	1	1. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. 1 ☒ Yes 2 □ No 1951 If Yes, Give Year or Dates:	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc. White						
ted		15. Decedent's Education (Specify only highest grade completed)		nt's Usual Occupa		16	b. Kind of Busine	ess/Industry			
Completed		Elementary/Secondary (0-12) College (1-4or 5+)	`life. DC	NOT use retired)			hemical	Industry			
To Be (17. Father's Name (<i>First, Middle, Last</i>) Oliver Tibbitt				e (First, Middle, Mai Stubbs Tib	,				
						ral Route Number, C ; Denton,					
	2	1 X Burial 2 Cremation 3 D Removal from State	etery, crema	tion (Name of atory or other place o Cemete:	9) ;		c. Location - City reensbor	or Town, State			
	2	21. Signature of Funeral Service Licensee	F1e PO	Name and Addresses and Box 160;	s of Facility Helfenb Greensb	ein Funer oro, Mary	al Home land 21	639 ^{PA}			
	1	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequent of the consequent of the cause)	onic	the mode of dying	j, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death			
cal Examiner	ti	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
hysician/Medical		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3□E	Ectopic pregnancy Other (specify)	-teet.		23d. Date of Month	delivery Day Year			
by P	P	Part II. Other significant conditions contributing to death but not resulting	ng in the und	lerlying cause give	n in Part I.	23e. Did tobac		te to the cause of death? Probably 4 ☐ Unknow			
Completed	-					24a. Was an autopsy performe.	prior				
Be (2	25. Was case referred to medical examiner?				th (Check only one)	\ I				
2	2		/Outpatient		4 Nursing H	ome 5 Residence		Specify)			
Certification:	2	12Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Bb. Time of Injury		at ? ′es 2 □ No	28d. Describe how					
ertifi		4 ☐ Homicide determined 206. Face of injury Actionic building, etc. (Specify)				City or Town, S	State)	r Rural Route Number,			
O	2	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the time estigation, in my op	e, date and place pinion, death occu	, and due to the caus rred at the time, date	se(s) and manne e and place, and	er as stated. due to the cause(s)			
	2	29b. Signature and title of certifier		29c. License				Ionth, Day, Year)			
Medical C	-	1) -1 ()		1 5 0		A	1 1	(
		30. Name and address of person who completed cause of death (Item 23	Ba) (Type Pr	rint)	00298	18 1	tarch	22,2008 2160			

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day

2008

March

Physician
/Medical
Examiner

1 - For State Registrar

Charles Tulip, Jr.

Funeral

Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

> Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached

Division or Vital Records, P.O. Box 68760,

r	4a. Facility Name (If not institution, give street and number)	4b. (City, Town, or Location	n of Death		4c.	County of D	eath			
	Anne Arundel Medical Center		Annap					nne Arundel			
	5. Social Security Number 385–32–5586 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthda. 73 Yrs.	y) If U Mor		er 24 Hrs. Min.	8. Date of Birt (Month, Da June 1	y, Year)	934	Birthplace (State or Foreign Country) New York			
tor	Usual Residence of Decedent 10a. State 10b. County Maryland Queen Anne 10c. City, Town or	Location	ocation Chester					10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
al Direc	10e. Street and Number 8001 Bridge Point Drive	10	10f. Zip Code 10g. Citizet 21619					Country?			
ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	3. Was E	Decedent of Hispanic (, specify Cuban, Mexic	Origin? (Spe	cify Yes or No Rican, etc.)	-		American Indian, Vhite, etc.			
To Be Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		es 2 ∑ No <i>Speci</i> i	fy:		121 16	Specify:	White			
ete	(Specify only highest grade completed) (Gi	ve kind o	Usual Occupation of work done during m OT use retired)	ost of worki	ng	16D. K	nd of Busine	ess/industry			
Omo	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Comp	otroller			U.S	. Gove	ernment			
o Be C	17. Father's Name (First, Middle, Last) Charles Tulip			ther's Name Else V	(First, Middle, Viese	, Maiden	Surname)				
			dress (Street and Nun								
	20a. Method of Disposition 20b. Place of Dis	position	(Name of y or other place)		ate	20c. Lo	cation - City	or Town, State			
		ore (Crematory					e, Maryland			
	21. Signature of Fineral Servige Licensee		ne and Address of Fac			_					
	23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.						парот.	Approximate Interval Between			
	Immediate Cause (Final disease or condition resulting in death) A Myocardial Infar							one day			
	Due to (or as a consequence of):										
ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
min	Sequentially list conditions, if any, leading to immediate course. Experimentally list constraint Cause (Disease or injury that initiated events										
cal Ex	resulting in death) Last Due to (or as a consequence of):										
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown										
	Part II. Other significant conditions contributing to death but not resulting in the	e underly	ying cause given in Pa	ırt I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown						
sted	,										
Be Completed by					24a. Was auto perf 1∐ Yes		prio dea	re autopsy findings available r to completion of cause of th? Yes 2 □ No			
Be	25. Was case referred to medical examiner? Hospital: Hospital: 4 Description CENTRO CE	tiont 2	Othor		Check onl	1.7	c Dother	(Canada)			
: To	1 ☐ Yes 2 № No	e of	28c. Injury at Work?		me 5 Res 28d. Describe			Specily)			
atior	1 Natural 5 Pending (Month, Day Year) Injui 2 Accident investigation	ry N		□No							
ertifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, f	actory, office		28f. Location City or To			or Rural Route Number,			
Medical Certification: To	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, do not not not not not not not not not no	eath occ or investi	curred at the time, date gation, in my opinion,	and place, death occur	and due to the red at the time	e cause(s	s) and mann od place, and	er as stated. d due to the cause(s)			
Me	29b. Signature and title of certifier Businetta Chille Mp		29c. License numb					Month, Day, Year) 8, 2008			
	30. Name and address of person who completed cause of death (Item 23a) (Tyle Birgitta E. Miller, MD 2003 Medical			ite 10	00 Ann	apo]	is, Ma	aryland 2140			
te	31. Date filed (Month, Day, Year) 22. Registrar's Signature										
ar	MAR 2 0 2008 Keepen &	BALL									
01											

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:35 **Physician** ICKERS MARCH 20 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HESTERTOWN NURSING FREHAS, CENTER CHESTERTON KENT If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth
 (Month, Day. 9. Birthplace (State or Foreign Country) 5. Social Security Number Year) **Funeral** Days 1 M 2 □ F FEB 224 12 1889 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show at 1 Yes 2 □ No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notifiled HESTERTOWN MD KENT Director 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code U.S. A 21620 WASHINGTON AUENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dryes 2 No WWIII Intes. Give Year or Dates: (140 45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) - LORIST TLORIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F VICKERS KEBECCA WILSEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🧲 🗲 🍎 🍞 4315 FREEMONT AVE. SOUTH MINNEAPERIS 27 JEAN permit. Pages 1 ai Department of Heal. Important: If item 2, any injury. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State CEMETERY HESTER HESTERTOWN, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GREEN 205 MDOOGET WILLIAMS, JL MARVIN With E CHESTERTOWN MP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as conshock, in heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) burial-trar and Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the proderlying cause given in Part I. ģ 3 ☐ Probably 1 🗌 Yes 2\□ No 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day) 28d. Describe how injury occurred 28b. Time of Manner of Death 28c. Injury at Work? After 'Year) 5 Pending investigation Natural after death. 1 🗌 Yes 2 No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person w

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cause of death (Item 23a) (Type, Print)

00517

ANDREWS. FERGUSON

		For	Please			nd / Depa	artment of F	lealth and N	•		egible.	
		Registrar				Ce	rtificate of	Death		Reg. No.	2008	0.5
Physicia	an a	1. Decedent's Nam	e (First, Middle, Las	t)					2. Date of Dea Month	ath Day	Year	3. Time of Death
/Medic		EVA MAE	WOODRUM						MARCH	20	2008	5:40 A M
Examin		4a. Facility Name (/	f not institution, give	street and num	nber)		4b. City, Town, o	r Location of Death		4c. Co	ounty of Death	
		MEMORIAL	HOSPITAL				CUMBER				LLEGAN	Y
Funeral		5. Social Security N	1	ex □M 2Q+F		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Yea <i>r)</i>	9. Birth	place (State or Foreign intry)
Director		217-72-2	100		90	Yrs.			5-3-1	917		MD
and W	Director	Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
anyla sho		roa. Otato										1 🛣 es 2 🗆 No
with the Maryland to or 28a-f show the notified at		MD	ALLEGAN	<u>Y</u>	EL.	LERSLIE				10a Citizo	n of What Cou	mate O
with t	声	10e. Street and Nu					10f. Zip Code			rog. Citize	II OI WHAT COL	illuy?
± 83 ₹	Funeral		YBARGER L				21529	lii- O-i-i-0 (O-			SA . Race - Ameri	oon Indian
er de item ner n	ű,	11. Marital Status	ind Well Marriad	12. Was Dece Armed For	ces?	J.S. 13.	If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White	
rs aft	by F	3 ☐ Widowed	ried 2 Married	1 ∐Yes If Yes, Giv Year or Da	eX		1 ☐ Yes 2 X No	Specify:		S	pecify: WHI	rr
houn tura			15. Decedent's Ed			16a. Dece	dent's Usual Occup	pation			of Business/II	
in 72 1 "na ledic	olet		cify only highest gra	de completed)		(Give	kind of work done DO NOT use retire	during most of work d)	king			,
with iene. thar he N	Completed	Elementary/Seco	ondary (0-12)	College (1	-4or 5+)	н	MEMAKER			OM	N_HOME	
filed Hyg other	Ö		(First, Middle, Last)				MILI DANCIN	18. Mother's Nam	e (First, Middle,			-1
d be ental ced c	o Be	WTLLTAM	AMBROSE	MTLLER				EDITH MA	E LOWER	Y		
should be ind Mental ind marked o	ဥ		ame/Relationship (7			19b. Maili	na Address (Street	and Number or Rui			own State Z	n Code)
s 1 and 2 should be filed within 72 hours after dea f Health and Mental Hyglene. Item 27 Is marked other than "natural", or items other traumatic event, the Medical Examiner m					ATTO							,
permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra		20a. Method of Dis	• WOODRUM	/ HUSBA		Place of Dispo	osition (Name of	ER LN. PO	Date IU		ERSLIE tion - City or 1	
nt of nt of t: If H			□Cremation 3K		State	-	matory or other pla		2000	T A 77 A	TE MT	
it. Purtme			5 Other (Specify uneral Service Licen	' 	Kı			DENS 3-22 Pess of FacilityHAR			LE, MD	PDAT HOME
permit Depar Impor any ir		21. Signature of Pt	IT TOO IN THE	1/4/	1.			NCE ST.,				ERAL HOME
	F0 1	C JUL	OFFUF II	1-11/11							JJ4J	Approximate
			the disease, or compart failu . List only					ng, such as cardiac	or respiratory at	rest,		Interval Between Onset and Death
Physician		Immediate Cause disease or condition resulting in death)	(Final on	a. Keno	w .	failu	86					5 days
/Medical Examiner		resulting in death)		Due to (or as a conse	quence of):	. 10	1940				7
L Adminier	L	Sequentially list co	enditions,	b. Con	gest	ve_	hears +	far	lure		-	1 9945
sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										J
executed in and ial-transit	cam	that initiated events resulting in death)	S	C								
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ate b hysic the b	lical			.d								·
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	IF FEMALE:								1000		
ath ce tendi	an/	23b. Was deceden		23c. If yes, outo	come pfpregr inth 2 ∐ Fet		⊒Ectopic pregnanc	·y		23	d. Date of deli	very Day Year
e dea	sici	1 ☐ Yes 2 l	7No	4□Pregn 9□Unkno	ant at time of	death 5[Other (specify)				WOITH	Day Tour
at the	μŞ	9 ☐ Unknowr	'									
v requires that the d been signed by the should be detached	by	O -	ficant conditions c	_	eath but not re	-	inderlying cause giv	ven in Part I.				the cause of death?
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law r as be 2 sh	ple		1						24a. Was			opsy findings available ompletion of cause of
rsiclan; The law s certificate has t lirector, page 2 s	Completed								perfo	rmed?	death?	2 No
an; rtifica tor, p	Be C	25. Was case refe	rred to medical					26. Place of Dea				
Physiclan; r this certificaral director, I	.0	examiner? 1 ☐ Yes 2	(No	Hospital:	npatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	ner: 4 🗆 Nursing He	ome 5 Resid	dence 6 [☐Other (Spec	ify)
50 0 0 0		27. Manner of Dear		28a. Date o		28b. Time o	of 28c. Inju		28d. Describe l			
or Attending Inter death. Director: After in by the fune	atio	1 ☑ N atural 2 ☐ Accident	5 ☐ Pending investigation		n, Day Tear)	Injury		Yes 2 □ No				
Atte	ific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe. Flace	of injury - At I		reet, factory, office				Number or Ru	ral Route Number,
al or safte	Certification:	4 I Horrida		Dalidii	ig, etc. (Spec	uy)			City or Tov	vii, Sialej		
spits hours inera y fille	<u>a</u>	29a. Certifier						ime, date and place				
e Ho 1 24 I ie Fu	Medical	(Check only one)	2∐ Medical Exam	niner: On the ba and manr	asis of examin ner stated.	nation and/or in	rvestigation, in my	opinion, death occu	rred at the time,	date and p	lace, and due	to the cause(s)
To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Me	29b. Signature and	title of certifier	1.	(red	×	29c. Licens	se number			signed (Month	
6				Afril	,		DI	THAN	8	315	20108	•
		30. Name and add	ress of person who	completed cause	e of death (Ite	m 23a) (Tvne	Print)	40.,				
nds		7 1	19. Ahm	ad C	1025	seton	Drive	Cumbe	-land	M	D 21	502
Sta	te	31. Date filed (Mor	nth, Day, Year)	32. R	egistrar's Sign	nature		Cumbe		· · · · ·		
Registr		MAI	K Z 1 Z008	A COL	ie St	April						

			For State Registrar			/ Depa		f Hea	lth and I	Mental Hygi	•	8 (11052
			Decedent's Name (First, Middle, Last))						2. Date of Death	1		3. Time of Death
	/Medi	cal	Mayson Douglas 4a. Facility Name (If not institution, give	Waters			4b. City, Tow	n. or Loca	ation of Death	MARCH	Day 10 20 4c. County o		02:23 PM
	Examir	ner		entist Ho	_			kvil			Mont	o Ome	erv
	Funeral		5. Social Security Number 6. Sex	7. Ag	ge (In yrs. las	t birthday)	If Under 1 Ye	ear If L	Inder 24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign ntry)
	Director		213-81-7361	≹M 2□F		0 Yrs.	Months Da		ours Min.	Jan. 16.			ryland
P	*		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation						10d. Inside City Limits
laryla	sho m	'n											1 ☐ Yes 2 ☐ No
the N	28a-f	Directo	Maryland Montgon 10e. Street and Number	<u>iery</u>	L	Gaith	10f. Zip Coo			10	g. Citizen of Wi	hat Cou	
with	l ke			D1						"			
-0036 hours after death with the Maryland	ital hygiene. ki othar then "natural", or liams 23a or 28a-f show evant, ita Medical Evat-di sermasi ke notifiad at	Funeral	8839 Cross Countr	12. Was Decedent	Ever in U.S.	13. \		0879 of Hispan	ic Origin? (S	pecify Yes or No-	United 14. Race		ates can Indian,
ifter O	r ta	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐	?					pecify Yes or No- o Rican, etc.)		, White,	etc.
	- H	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀	No Sp	ecify:		Specify:	Mixe	ed
2 PC 2	fical	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	1	16a. Deced	dent's Usual Oc	cupation	most of wor	kina 1	6b. Kind of Bus	iness/In	ndustry
Z ug	en	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work do DO NOT use re	tired)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
1d 21215-(ygier har tr	Co	0			N	lone	10		450 A A C A C			one
	otal H	Be	17. Father's Name (First, Middle, Last)							ne (First, Middle, M		,	
arylan should be	nd Menta markad matic ev	မ	Jevon D. Wate			405 M-15-	- 444 (04		Meliss		mmons		- Codel
Maryland 21215-0036 d2 should be filed within 72 hours af	h and 7 Is r traur		19a. Informant's Name/Relationship (Ty							ral Route Number,	-		
a .	Department of Health and Men Important: If itsm 27 is marka any injury or othar traumatic once.	1	Melissa Waters / 20a. Method of Disposition	Mother	20b, Plac	e of Dispo	sition (Name o	f	y PI,	Gaithers Date 2	Oc. Location - C		
Pages			1 🔀 Burial 2 🗆 Cremation 3 🗆 R	emoval from State	cem	etery, cren	natory or other	place)					
Baltimore, permit. Pages 1 ar	artme ortani injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice License 	ee	Gate		. Name and Ad			17/2008_		Spr	ing, MD
Balti Permit.	Depa Impo any ir					à			5.	imple Tri		20	0.50
			23a. Part1. Enter the disease or complishock, or heart failure. List only or	ications that causer	d the death.					e, Rockvi or respiratory arres			Approximate
Lpty	ysician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	NECRO					ocol				Interval Between Onset and Death
/0	Medical		resulting in death)	Due to (or as			0,4,	071	- 4	. 7.0		\neg	
Ex	aminer		Samuelially list our differe	EXTA	EME	TRI	EMATO	JR17	4				
P	Ħ	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	nce of):			~				
ecute	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last)								_	
/6U, te be executed	ysician and he burial-transit		rosaning in osain, cast	Due to (or as	a consequen	ice or):							
	physic the t	dlcal		l								100	
	attending phy s for use as the	by Physician/Med	IF FEMALE:	3c. If yes, outcome	of pregnancy	v					23d. Date	of dollar	an/
BOX eath cer	atten for u	cian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal de	ath 3	Ectopic pregna Other (specify				Mont		Day Year
i g	y the iched	ysi	1 □ Yes 2 No 9 □ Unknown	9☐ Unknown			z canor (opcon)						
J ₽	been signed by the should be detached	Y P	Part II. Other significant conditions con	tributing to death b	out not resultin	ng in the ur	nderlying cause	given in	Part I.	23e. Did toba	acco use contrib	oute to t	he cause of death?
rds quires	n sigr uld be									1 ☐ Yes	2 □ No 3	∃ □ Prot	bably 4 Unknown
Ö ĕ	shou	Completed								24a. Was an	24b. W	ere auto	opsy findings available
<u>\$</u> ₽	ate has page 2 s	m _C					_			autopsy	ed? de	ior to co eath?	mpletion of cause of
_	certificate rector, pag	0	25. Was case referred to medical					26	Place of Dea	th (Check only one	, , , , , , , , , , , , , , , , , , , ,	_] Yes	2 No
49		0 0	examiner? 1 ☐ Yes 2 X No	lospital: 1 Inpatie	ent 2□ER	/Outpatien	t 3 DOA	Other		ome 5 Resider		(Specil	fv)
of g Phy	두 급	T in	27. Manner of Death	28a. Date of Inju (Month, Da	ıry 28	Bb. Time of Injury	28c.	njury at Work?		28d. Describe how			
VISION	ath. or:Afr oe fur	atlo	1 XNatural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , ,	,,		1 🗆 Yes	2 🗆 No				
UIVISION I or Attanding	iracto iracto Ibytl	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	jury - At home tc. <i>(Specify)</i>	e, farm, stre	eet, factory, off	ice		28f. Location (Stre City or Town,		or Rura	ai Route Number,
ا ۾	rs all												
na Hosp	within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer.	Medical	29a. Certifier (Check only one) Certifying Phys Certifying Phys Certifying Phys Medical Examin	sician: To the best ner: On the basis of and manner sta	of my knowle of examination ated.	edge, death and/or inv	occurred at the restigation, in n	e time, da ny opinior	ate and place n, death occu	, and due to the car rred at the time, da	use(s) and man te and place, ar	ner as s id due tr	stated. o the cause(s)
To tha	With To th comp		29b. Signature and title of certifier	<u> </u>				ense nun	-	1	d. Date signed		
j							5	146	01		ン /じ	0/	08
1			30. Name and orders of person who co TAMES ROST, SC 31. Date (field (Month, Day, Year)	mpleted cause of d	teath (Item 23	3a) (Type, I	Print)	R. DR	ive R	WK VIIIE	MARILLA	24/1	20850
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pa pistr	rar's Signature	9	4		//	unviou	11/11/14	100	<u></u>
44	Registr	-	MAR 2 0 20	108	us l	1. 1	marke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 360 AM BUBS18 LUG15H .2 2008 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Numbe 218-30-0291 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/25/1935 Birthplace (State or Foreign Country)
 TN 7. Age (In yrs. last birthday) 73 yrs **Funeral** Days 1 M 2 CXF **Director** Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Bedford Shelbyville TN 1 ☐ Yes 2☐No 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code 23a or traumatic event, the Medical Examiner must be 37160 USA 183 Cedar Grove Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 11 Marital Status Black, White, etc. 1 ☐ Yes **2√X**No If Yes, Give Year or Dates: 1 Never Married 2 Married White 5-0036 1 ☐ Yes 2 🔼 No Specify by Specify: 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Maryland 2121 College (1-4or 5+) Elementary/Secondary (0-12) Clerical 0il Company 11 and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Lucille Nelson R.S. Arnold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Millersville, MD 21108 1604 Millersville Rd. Department of Health a Important: If Item 27 is any injury or other tra Sister Shirley Deinlein 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XX urial 2 □ Cremation 3 □ Removal from State Willow Mount Cemetery 3/21/2008 Shelbyville, TN 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Icensee 22. Name and Address of Facilit Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MI /Medical Due to (or as a consequence of): Examiner Ses ported CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Considers of injury Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has tirector, page 2 s autopsy performe or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA P this 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation To the Hospita. ..
within 24 hours after death.
To the Funeral Director: Aft 1-Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 130768

CH 4.

State Registrar 31. Date filed (Month, Day, Year) MAR 2 0 2008

Jackson

32. Pysistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

w .

		1	For State	State of Ma		/ Depa	artmer		ealth and l	Mental Hy	giene	egible.	n and
G13		_	Registrar 1. Decedent's Name (First, Middle, L	ast)		Oei	lilica	ie oi L	Jean	2. Date of De Month	ath Day	200 (Year	3. Time of Death
Phys /Me	iciar dica		DONALD FRANCIS V				4. 0	T	L	MARC	Н 20,	2008	6:30 A ^M
Exan	nine		4a. Facility Name (If not institution, g						Location of Deatl	1		County of Dear ENT	tri
Funer	ai	Months Days Hours Min									th y, Year)	9. Bir	thplace (State or Foreign
Direct	or		569-14-9442 Usual Residence of Decedent	1 X M 2 F	87	Yrs.	Morkino	Duyo	110010	7/7/			IA
/land low		- 1-	10a. State 10b. County		10c. City, 1	Town or Lo	cation			-			10d. Inside City Limits
e Mar ta-f sh	å	5	MD KENT]	ROCK 1	HALL						1 □Yes 2¶No
with th a or 24 be no			10e. Street and Number 7038 SWAN CREEK	PΠ				р Code 21661			10g. Citiz	en of What Co	ountry?
death ms 23 must	100	<u>u</u>	11. Marital Status	12. Was Decedent E	ver in U.S.	13. \	Was Dece	edent of His	spanic Origin? (S	pecify Yes or No	- 1	USA 4. Race - Ame	
urs after al", or iter xaminer		Dy ru	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:			if Yes, spo 1 ☐ Yes		n, Mexican, Puèr Specify:	to Rican, etc.)		Black, White Specify:	HITE
ite; INIAI yial IO Z IZ IS-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If then 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		naiaidiiino	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5-		16a. Deced (Give life. L	kind of w	ual Occupa ork done d use retired,	lurina most of wo	rking	16b. Kir	d of Business	/Industry
d with yiene or tha	1	5	12	5+	-	EXEC	UTIV	Ε				PPING	
be file d oth	á	מ	17. Father's Name (First, Middle, Las	st)						me (First, Middle	, Maiden S	Surname)	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Maumatic event, the Market Bar	F	2	CHARLES WIERDA 19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Addres	s (Street a	ANNE DU	NN ural Route Numb	er, City or	Town, State,	Zip Code)
2 6 4 6			ELFRIEDE WIERDA,	/WIFE		7038	SWAI	N CRE	EK RD. F	OCK HAL	L, MI	21661	
Darkillofe, IV permit. Pages 1 and. Department of Health Important: If Item 27 any injury or other tr			20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cen	ce of Disponetery, cres	matory or	other plac	i	Date 21/08		cation - City or VENSVIL	
partillor permit. Pages Department of Important: If it any injury or or	ouce.	ł	21. Signature of Funeral Service Lic		OHLIDA	22	2 Name a	and Address	s of Facility	N & NEW			
0 88E E	0	4	Guentellows		ale e de edle	1	30 SI	PEER	RD. CHES	TERTOWN	, MD		Approximate
Physicia /Medic Examin	al		23a. Lentr. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each lin	9/0	nic			v mm	12	/		Interval Between Onset and Death
ou, be executed cian and ourial-transit		iicai Exaliiiler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o. Ch	o (or as a consequence of): having Lymphy Five o (or as a consequence of):						Wla	Mol	
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the to completely filled.		Filysician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	leath 3	⊒Ectopic ⊒ Other (s	pregnancy specify)			2	3d. Date of de Month	elivery Day Year
w requires that been signed by should be deta	3	2	Part II. Other significant conditions	s contributing to death bu	ut not resulti	ing in the u	ınderlying	cause give	en in Par t I.				o the cause of death?
The law required that has been page 2 shou		Completed								24a. Was auto perfi 1□ Yes		24b. Were a prior to death?	
VICAL rsician: ' s certifical lirector, p	É	0 0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №0	Hospital: 1 ☐ Inpatie	ent 2 🗆 El	R/Outpatier	nt 3□□	OOA Othe	or:	ath (Check only only only only only only only only		S ∏Other (Sp	ec/fv)
SICIL OF tending Phy leath. tor: After this the funeral of		tion: 10	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Day	ry 2	28b. Time o Injury		28c. Injun Work		28d. Describe			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifical completely filled in by the funeral director,		Certification:	3 Suicide 6 Could not determine		ury - At hom c. (Specify)	ne, farm, str	reet, facto	ory, office		28f. Location (City or To	Street and wn, State	d Number or F)	Bural Route Number,
e Hospita 24 hours e Funeral		edical C		Physician: To the best of taminer: On the basis of and manner sta	f examination								
To th within To th	:	Me	29b. Signature and title of certifier	7).			2	9c. License	e number		29d. Dat	e signed (Mor	nth, Day, Year)
15			51	Jely m	-			シ	36057		3	120/0	8
7			30. Name and address of person wh	no completed cause of d	eath (Item 2	23a) (Type,	Print)	SRI	Blok	Chest	erto	W M	02/620
	Stat istra		31. Date filed (Month, Day, Year)	ZUUO 32. Registra	ar's Signatu	ire	Disease.	1	7				

08-024	156
Cathy	Miller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ithy Miller	1	State of Maryland / Department of the For State Certificate of Department of the Certificate of the		in U t	10 1105		
Physicia	in/	Registrar 1. Decedent's Name (First, Middle, Last) Catherine Maria Miller	2. 🗅	Reg. No.	3. Time of Death		
edical Exami	ner	Catherine Maria Winner	M	Month Day Year larch 28, 2008	1723 hrs		
		4a. Facility Name (if not institution, give street and number) 4b. C	ity, Town, or Location of Death	i '	4c. County of Death		
		10000 Fredrick William Fredrick	ostburg	Allegany Date of Birth(MM/DD/YYYY) 9. Bir	dhalaaa (Stata ar		
Funeral	- 1	M		Foreign			
Director	L	217-82-9213 1□M 2 X F 48 Yrs. M)9=16=19J9 C	durity) [4D		
any	- }	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits		
A .		MD Allegany Frostburg			1 Yes 2 No		
e Maryland or 28a-f show	황	3	f. Zip Code	10g. Citizen of What Cou	•		
or 28	Director	10300 Frederick J. Winner Road	21532	United S	States		
with the same of a same			cedent of Hispanic Origin? (Specif	y Yes or No- 14. Race - Amer	rican Indian, Black,		
death r item	Funeral	Never Married 2 Married 1 Yes 2 No	pecify Cuban, Mexican, Puerto Rica	,	nite		
after o	by Γ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes	No specify:	Specify:			
hours natur	eted t	during most of	sual Occupation (Give kind of work of working life, DO NOT use retired)		rindustry		
36 in 72 han "	E E	Elementary/Secondary (0-12) College (1-4 or 5+) 2 Phlebot	tomist	Health			
Sylene ther t	omple	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Surname)			
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Frederick J. Winner	Evelyn C.	. McKenzie Wir	nner		
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mandal Hygie within 72 hours after death with the Maryland tem 21 is marked other than "natural", or items 23a or 28a-1 sh traumatic event, the Medical Examiner must be notified at once	P	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Add		Route Number, City or Town, Stat			
MD id 2 sho alth and m 27 is aumati		Gregory Winner nusband 10300		Winner Road Fi			
re, S I an f Hea If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other p	place)				
MOFE Pages I nent of I ant: If i		4 Donation 5 Other Specify: Miller Fa		2008 Frostburg	g, MD		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Head and Meantl Hygene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical.		11 min /	e and Address of Facility	ers Funeral Herostburg, MD 2	ome, P.A.		
		Alen Sowers Moos 47 60 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	W. Main St. E	rostburg, MD 2.	1532 Approximate Interval		
Physician 'Medical		failure. List only one cause on each line.	loge of tyling, oddir do od diago or re-		Between Onset and Death		
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Anaphylaxis Due to (or as a consequence of):			 		
		Sequentially list conditions, b					
	ner	if any, leading to immediate Due to (or as a consequence of):					
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760, cate be executed physician and he burial - transit	Medical	X unpended X amenged, per INf, #1,23a,27,2	28a-f. perME.g879 5/8	8/08 TT			
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ords, F w requires s been sig should be	lete			autopsy prior to	autopsy findings available o completion of cause of		
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Of ing Pl After unera	i.i	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)		3d. Describe how injury occurred			
ion tend teath.	atic	2 X Accident Investigation 3/28/2008 unk		acute allergic react 3f. Location (Street and Number or			
Vision A after after Direction by	Certification:	3 Suicide 6 Could not be determined (Specify) residence		or Town, State) 0300 Frederick Winne			
spital hours meral y fille	Š	4 Homicide					
Livision of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after each. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred one) Wedical Examiner:On the basis of examination and/or investigation	, in my opinion, death occurred at the	ne time, date and place, and due to	the cause(s)		
To T	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (#			
		Canal Laclan	O.C.M.E.	March 29, 200	8		
	1	30. Name and address of person who completed cause of death (Item 23a)					
	12. 11		eet, Baltimore, MD 21201				
S	tate	31. Date filed (Month, Day, Year) 34. Registrar's Signature					
Regis	trar		<u></u>				
DHMH 17 Rev 1/	2001	ORIGINAL					

State of Maryland / Department of Health and Mental Hygiene 📋 🗋 🥱 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7:20 P.M MARCH 2008 21, REATHEL MILDRED YODERS /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CUMBERLAND ALLEGANY DEVLIN MANOR NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 98 1 ☐ M 2 🖫 🕶 213-22**-**3867 WEST VIRGINIA MARCH 15,1910 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28a-f show the Medical Examinar rital be intillised at 1 X Yes 2 ☐ No CUMBERLAND Director ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 U.S.A. 135 N. MECHANIC STREET, #210 by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 ie merkad other than "natural", or Ite any injury or other traumatic event, the Medical Examina 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 □ Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maryland Be BENJAMIN FRANKLIN WILKINS ARSINA SAVILLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1068 NATIONAL HIGHWAY, LAVALE, MD SYLVIA HEDRICK / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State REST LAWN MEML. GDNS. 03/25/2008 * 4 ☐ Donation 5 ☐ Other (Specify) LAVALE, MD 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, MD 21. Signature of Funeral Service Licensee exclude V 21502 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** 5 Clery sev /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, from leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Be Completed by Physician/Medical Examiner burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 Ne 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 DNatural to Funeral Director: Alt letely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical npletely (Check only one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Mar. 25, 2008 m N D 6017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LaUxie 21501 922 NiT1 AJ BUILTAO MD

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year, MAR 2 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 23a per dr., 1878, Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Day 30 **Physician** Frances Ε. Braun 2000 /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Glen Medical Center | Tunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 22,1922 Arundel Anne 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 220-14-4689 Washington, D.C **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location and Mental Hygiene. Is marked other than "ratural" or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10b. County 1 ☐ Yes 2 X No Director MD Anne Arundel Severna Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18 Madary Road 21146 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Department of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Harvey E. Behringer Sr. Mary E. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 359 Freshfields Lane Arnold, MD 21012 Mrs. Karen L. Byrd/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 3 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2008 Crownsville, MD. 4 Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** KENAI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urosepsis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed Exami ing physician and as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) ned by the a 9□ Unknown 9 Unknown signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.2 No 1∐ Yes ul or Attending Physician: a er death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗽 No 1 🔀 Inpatient funeral din ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO27415 Mouch 30, 2008 namen

DHMH 17 Rev 1/2001

State

Registrar

marke

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Drive Glen Burnie, MD 21061 Henry Francis MD, Buttomare Washing En Merical Center

Registrar

State

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5:00A M assie M. 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 5402 Pembrole Avenue GWYNN Oak If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth (Manth, Day, Birthplace (State or Foreign Country) **Funeral** Hours Months Days 245.82.3570 1 M 2 F 0 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Show r 28a-f show notified at MD Baltimore Oak 1 Yes 2 No GWUNN **Funeral Director** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 Pembroke Avenue 5402 21207 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 7 is marked other than "natural", or items traumatic event, the Medical Examiner me 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 X No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Back Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Springtield 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Nurse Assistant Hospital 12th grade 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanle Caston Simmons 1-10551E 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Gwynn Oak MD 21207 nt of Health a Husband Department of Health Important: If Item 27 any injury or other troonce. 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 04105108 Windsor Mill, MD Memorial 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Senices 21. Signature of Funeral Service Licens 8728 Liberty Road MO 1401 Randallstown MD 21133 23a. Part. Enter the dis-stock, or heart faild Imm. late Cause (Final disease or condition resulting in death) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death led by the a 9☐Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? And ning 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ۵ 1 Inpatient 28a. Date of Injury 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cent

State Registrar 0

31. Date filed (Month,

Month, Day, APR 0 istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year =49AM **Physician** Blancha 03 29 2008 Denise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** /A Baltimore Manyland of Conversity If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Days Director and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? rubin Ct. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 480x 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5307 Department of Health a Important: if item 27 is any injury or other trainonce. Baltimere, MD 21206 Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 18/08 Baltimore, Mb Baltimarecemeter 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 7+~ MO1363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death pertention Immediate Cause (Final over 3 475 Physician disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burlal-tra Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒️No 24a. Was an autopsy perform Yes 2 page 2 this certificate 2☐No director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: Division 1 Natural 5 Pending within 24 hours after control to the Funeral Director: After To the Funeral Director: After To the Funeral Hilled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2008 204218228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bateimore 19D 21201 Xingyi Que 5 Coverne 2 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 02^{ay} 200⁸ Benjamin 0. Brookhart, Jr. A M 7:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 122 Hahn Rd. Westminster Carroll 8. Date of Birth (Month, Day, Year) Jan. 22, 1916 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Hours 12 M 2□F 92 212-03-4549 **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Md. Carroll 1 ☐ Yes 2 ☐ No Director Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be r 122 Hahn Road 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced White Completed er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) +2 Elementary/Secondary (0-12) Draftsman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin 0. Brookhart, Sr. Julia Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Judy Gagnon/ Daughter 122 Hahn Road Westminster, Md. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Druid Ridge Cem. 4-7-08 Pikesville, Md. 22. Name aracks Towson Funeral Home, 21. Signature of Funeral Service Licens 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it and a sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician at the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 | Yes 2 → Ho 1 Inpatient ၉ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Atatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: Director: within 24 hours a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			Registrar 1. Decedent's Name (First, Middle, Last)		imouto or		2. Date of Death	g. 140.	3. Time of Death
	Physici			Blase	11:	To	Month	Day Year 4 200 8	11:45 p.M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	LITASC		or Location of Death	April	4c. County of Death	
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	deal mms	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?			Hispanic Origin? (Specian, Mexican, Puerto R	ify Yes or No-	14. Race - Amer Black, White	
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O	ges tof H			20b. Place of Dispo cemetery, crei		ce)			
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Baltimore	permit. Pages Department of Important: If i any injury or once.		21. Signature Soneral Service Licensee	22	2. Name and Addre	Sonkling S	NOJA	Funcion	House
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× 6	The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23c. If yes, outcome of	nregnancy				22d Date of deli	
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of	Phys this al dii	<u>٥</u>	1 Tes 32NV0	2 ER/Outpatier	II 3LI DOA	4 Qursing Hom	e 5 Residen	ce 6 Other (Spec	ify)
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	Hos 24 h Fun Fun	Medical	(Check only one) Medical Examiner: On the basis of examiner and manner stated	amination and/or in	vestigation, in my	opinion, death occurred	d at the time, dat	e and place, and due	to the cause(s)
	o the	Me	29b. Signature and the of certifier		29c, Licens	se number	296	d. Date signed (Month	. Day, Year)
	r s r ö		M.	(-)	00	055171		04/50/	08
	1		30. Name and address of person who completed cause of deat	h (Item 23a) (Type			-	01/03/	-0
			Sahacha DL. 30	12 F-1	10.0 D	venne 1	Soltin	mar 21	224
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	Al a	- La water			
	Registr		APR 0 7 2008	Signature	and the second				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year 3, 5:20 P.M April /Wedical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Manor Care Potomac Potomac If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Months Days Min 1 X M 2 F Yrs. 8, 1925 Washington, D.C 216-22-0967 82 Nov. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 TYes 2 No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 103 Tschiffely Square Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner/President Plastics Company permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Cranford Martin J. Berghers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Tschiffely Square Rd., Gaithersburg, MD 20878 Ruth J. Berghers / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Apr. 5, 2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 21, Signature of Funeral Service Incenses M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician TVanco /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U. denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ☑ No page 2 autopsy performed? /es 2010o 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO054566 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bho Georgia Arence #1-17 Silverspring PDZoque 9801 31. Date filed (Month, Day, DUNITHA Year) 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9:32 A.M 2, Betty H. Baker April 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville Montgomery Rockville Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🖵 F 083-18-8731 83 March 17, 1925 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 1 No Virginia Fairfax McLean 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7002 Southridge Drive 22101 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify If Yes. Give 3 □ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) National Park Service Graphic Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert E. Haynes Frances M. Skidmore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John R. Baker 7002 Southridge Drive McLean, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Inc. April 4, 2008 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850 21. Signature of Funeral Service Libenses M00896 23a. Part 1. Entur the casease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause I III al Cerebrovascular Accident disease or condition resulting in death) Due to (or as a consequence of): Seizures Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hypertensive Heart Disease Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1∐Yes 2⊠No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

attending physician and for use as the burial-transi Box 68760, certificate be Physician/Medical signed by the a P.0 Division of Vital Records, \$ Be Completed certificate has this Certification: To

Physician

/Medical

Examiner

Director

Funeral

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and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examinar must be notified at

filed within 72 hours after

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permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any injury or other trau

Physician

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Examiner

Baltimore, Maryland 21215-0036

completely filled in by the funeral ie Hospital or Attendi 24 hours after death, ie Funeral Director: A death.

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Registrar

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D0047330

April 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Thomas V. Joseph, M.D., 50 West Edmonston Drive, #207, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

29a, Certifier

determined



		For State	State of Marylan	•	artment of F		-	200	19 11066				
		Registrar 1. Decedent's Name (First, Middle,	Last)		inicate of	Death	2. Date of De	Reg. No. 🚄 📙 📗	3. Time of Death				
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/Medi Exami		4a. Facility Name (If not institution,		1	4b. City, Town, o	or Location of Death		Death					
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permit. Page Department of Important: If any injury or once,		21. Anature of Funeral Service L	icensee // / / / /	Ci				ERAL HOM					
		222 Part 1 Enter the disease or	complications that caused the ceal	h Do not ent	412 E	PRESTON	ST. B	ALTO, MD.	Approximate				
	١.,	shock, or heart failure. List of Immediate Cause (Final	only one cause on each line.			3,	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death				
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ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of o		Other (specify)_	•		WOTE	Day Teal				
nat the d by the letache	Phy	9 ☐ Unknown Part II. Other significant conditio		uding in the u	ndoskina čeupo di	von in Dort I	220 Did	tobacco uso contribu	te to the cause of death?				
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w require been signature	ted	HYPERTENSION			SOTRUCT N	<u>'</u>							
Physician: The law requires t r this certificate has been signe rral director, page 2 should be o								psy prio	re autopsy findings available or to completion of cause of				
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ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Lou	har:	ath (Check only						
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death death ctor: y the f	fical	3 Suicide 6 Could n	ot be 28e. Place of injury - At h	l iome, farm, str	reet, factory, office		28f. Location	Street and Number of	or Rural Route Number,				
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after Dire	erti			owledge, deat	th occurred at the t	time, date and place			er as stated				
spltal or sours after neral Direction tilled in the	al Certification:		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at a manner at a medical examiner.										
e Hospital or a 124 hours after e Funeral Dire							urred at the time	, date and place, and					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	Medical Certi	(Check only 2 Medical I	xaminer: On the basis of examinand manner stated.	ation and/or ir	vestigation, in my 29c. Licen	opinion, death occ		29d. Date signed (A	I due to the cause(s) Month, Day, Year)				
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		(Check only 2 Medical E	xaminer: On the basis of examin-	ation and/or ir	vestigation, in my 29c. Licen	opinion, death occ		29d. Date signed (A	I due to the cause(s) Month, Day, Year)				
To the Hospital or. within 24 hours after To the Funeral Dire completely filled in It		(Check only 2 Medical E	xaminer: On the basis of examinand manner stated.	ation and/or ir	vestigation, in my 29c. Licen	opinion, death occ		29d. Date signed (A	I due to the cause(s) Month, Day, Year)				
To the Hospital or. within 24 hours after To the Funeral Dire completely filled in It		(Check only one) 29b. Signature and title of certifier	examiner: On the basis of examinand manner stated. M. D., who completed cause of death (Itel)	ation and/or in m 23a) (Type,	vestigation, in my 29c. Licen	opinion, death occ			I due to the cause(s) Month, Day, Year)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 9:15 P M Collison March 31, 2008 Diane /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 245 Severn Road Anne Arundel Millersville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 T 216-42-9547 63 Director Sept. 28, 1944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 TNo Director Anne Arundel Millersville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 245 Severn Road 21108 United States Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after ☐ Yes **★★**No f Yes, Give /ear or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Carroll Glen Greenstreet Henrietta Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 is any Injury or other trau 245 Severn Road, Millersville, Lynn N. Collison - husband MD 21108 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages ' April 4, 2008 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadowridge Mem. Pk. 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signatur of Funeral Service Licensee M00053 MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequent of): **Examiner** Cancer Sequentially list conditions, if any, loading to him edials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for a a consequence of Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy pertormed 1□ Yes 2□ No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760, within 24 hours after dear To the Funeral Director completely filled in by the the

> 0 State Registrar

Dr. Anita Khandelwal, 31. Date filed (Month, Day, Year)

undelwa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1406 South Crain Hwy., #106, Glen Burnie, MD 21060 32 Registrar's Signature

00052490

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner traust be notified at
Division of Vital Records, P.O. Box 68760, Se	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral Director

		For State Registrar	State o	f Marylan		artment of F		d Me	-	iene	2001	a line
		Decedent's Name (First, Middle, Language)	ast)			imouto or .		2.	Date of Deat			3. Time of Death
Physicia		Gertrude Campbel	1					A	pril 3	, ² 2008	Year	10:30 A.M
/Medic		4a. Facility Name (If not institution, gi		mber)		4b. City, Town, o	r Location of De			4c. Cour	nty of Death	
- Addition	•	8100 Connecticut	Ave., 4	1419	Chevy Ch	ase			Mont	gomer	У	
Funeral			Sex				If Under 24 H	Hrs. 8. vlin.	Date of Birth (Month, Day,	Year)	9. Birth Cou	place (State or Foreign ntry)
Director		3/9-90-/329	1□ M 2⋤F	91	Yrs.	Months Days			(Month, Day, an. 25	, 1917	Swi	tzerland
M		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
-f sho	tor	Maryland Montgom	erv	Chev	y Chas	se						1 ☐Yes 2X No
r 28a	Director	10e. Street and Number		1	<i>y</i>	10f. Zip Code			1	0g. Citizen o	of What Cou	ntry?
23a o		8100 Connecticut	Ave.,	#1419		20815			5	Switze	rland	
ems	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.S	S. 13.	Was Decedent of H	lispanic Origin?	? (Specif	y Yes or No-		ace - Ameri	
or It	by Fu	1 Never Married 2 Married	1 ∐Yes If Yes, Gi	2 ☑ No ive		I∐Yes 2⊠No	Specify:		, 0.0.,	Spe	oifu:	
tural" al Ex												
n "na	Completed	(Specify only highest gi	rade completed)		(Give	kind of work done of NOT use retired	during most of t	working		160. Kilid (i	buşiiless/ii	idustry
r thai	E O	Elementary/Secondary (0-12)	College (1	1-4or 5+)	Assist Defens	ant to se Attach	e		9	Swiss	Gover	nment
othe vent,	Be C	17. Father's Name (First, Middle, Las	t)				18. Mother's I	Name (F	irst, Middle, N	Maiden Surn	ame)	
Menta	10	Otto Eugen Frick					Alwina	Hupe	er			
Department of Health and Mental Hygiene, interpretant, for Items 23a or 28a-f show important; if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Experiment must be notified at once.		19a. Informant's Name/Relationship			1	g Address (Street						
health		David L. Scull /	Attorne		<u> </u>	Old Geor						
or of		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 [Removal from	State		sition (Name of natory or other plac	i	Date		20c. Locatio	-	
rtmer rtant njury		4 □ Donation 5 □ Other (Spec		Mont		Crematorium						
Depa Impo any I		21. Signature of Funeral Service Lice) O	M00896		57 Wisco						Chase, Inc. 14-3501
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that of one cause on e	caused the death	. Do not ent	er the mode of dyir	ng, such as can	rdiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
ysician		Immediate Cause (Final disease or condition resulting in death)	_{a.} Car	diopulmo	nary A	Arrest						Oliset and Death
ledical aminer		resulting in death)		(or as a consequ								
	-a	Sequentially list conditions,		ere Chro		bstructiv	re Lung	Dis	ease			
ansit	Examine	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
an an rial-tra		resulting in death) Last	ence of):									
physician and the burial-transit	dical		_ d									
ing pl	a	IF FEMALE:										
ttend or use	cian/M	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna birth 2□Fetal	death 3 [Ectopic pregnanc	y			23d. Date of delivery Month Day		very Day Year
the a	S	1 ☐ Yes 2 🔯 No 9 ☐ Unknown		4 ☐ Pregnant at time of death 5 ☐ Other (specify)								
ed by detac	Phy	Part II. Other significant conditions	contributing to d	eath but not resu	Iting in the ur	nderlying cause giv	en in Part I.	- 7	23e. Did tot	pacco use co	ontribute to	the cause of death?
ld be	d by	Hypertension							1 □ Ye	s 2 No	3 ⊠ Pro	bably 4 🗍 Unknown
shou	Completed	Carbondioxide Re	tention						24a. Was a	n 24	b. Were auto	opsy findings available
age 2	d mo							_	autops perforn	y ned?	prior to co death?	ompletion of cause of
rtifica tor, p	0	25. Was case referred to medical	T			<u> </u>	26. Place of I	Death (C	1 □ Yes 2 Check only on	2 🔀 No e)	1 □ Yes	2 L N0
direc	To B	examiner? 1 □ Yes 2 🙀 No	Hospital: 1	Inpatient 2	ER/Outpatier	t 3 DOA Oth	or:		5 📆 Reside	,	Other (Speci	ify)
fter th	:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mon	of Injury oth, Day, Year)	28b. Time of Injury	28c. Injur Wor	y at k?	280	l. Describe ho	w injury occ	urred	
or: A	cati	2 Accident investigation					Yes 2 □ No					
Direct Direct in by	ertification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place	e of Injury - At ho ing, etc. <i>(Sp</i> ec <i>if</i> y	me, farm, str ')	eet, factory, office		28f.	Location (St. City or Town	reet and Nu. n, State)	mber or Rur	al Route Number,
le le la	O	29a, Certifier 1 Certifying P	hysician: To the	hest of my know	wledge death	n occurred at the ti	me date and n	place are	d due to the c	auge(c) and	manner ac	stated
Fun Fun etely	Medical	(Check only one) (Check only one)	miner: On the b	pasis of examination stated.	ion and/or in	vestigation, in my o	ppinion, death o	occurred	at the time, d	ate and plac	e, and due t	to the cause(s)
To the	Me	29b. Signature and title of certifier	D	-		29c. Licens	e number		2	9d. Date sig	ned (Month,	Day, Year)
		Kaman	7/11	0,		D196	09		1	April	3, 20	08
4~	ŀ	30. Name and address of person who	completed caus	se of death (Item	23a) (Type,	Print)						
30		Raman Tuli, M.D.	, 10810	Darnest	own Ro	oad, Gait	hersbur	rg, l	Maryla:	nd 208	78	
Stat		31. Date filed (Month, Day, Year) APR 0 7 201	18 2. F	Registrar's Signat	ure	and the same						
Registra	ar i	APR V 1 201	1- 1-00	-	6							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Theresa Elizabeth Chenoweth 17:02 M April 2008 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** B Sinai nospital Baltriore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Bate of Birth (Month, Day, Year) March 27,1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 😿 F 217-18-9122 Baltimore MD 84 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director MD Carrol1 Svkesville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? If item 27 is marked other than "natural", or items 23a or or other traumatic event, the M. dical Examiner must be in 1124 Pouder Road 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation 12TH School bus Driver Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental ! Jacob A. Heckner Anna M. Plum ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a George Chenoweth (Husband) 1124 Pouder Road, Sykesville MD 21784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 4-10-08 Baltimore MD 21. Signature of Funeral Service Licensee Haight Funeral Home, PA. #M01314 po Box195 6416 Sykesville rd, Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Ventucular Da /Medical Due to (or as a consequence of): **Examiner** sestive 10 Day Sequentially list conditions, the base of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine 10 Days Due to (or as a consequer ce of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 | Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) 1. Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bhanne KES -000 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Registrar
DHMH 17 Rev 1/2001

State

Bhanna

31. Date filed (Month, Day, Year)

Gu

APR 0 7 2008

THERESA

HEND WELL

Sinai

MD

32 Registrar's Signature

			For State	State of Marylan	•			Mental Hy	giene	42	
			Registrar 1. Decedent's Name (First, Middle, Last)		Certi	ificate of l	Jeath	2. Date of Dea	Reg. No. ath	2008	3. Time of Death
	Physicia /Medic		1. Deceuents Name (First, Wildle, Lasty	JANE OAKLEY				APCI 1	2 pay	2008	815 am
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	400	City, Town, or	Location of Death	744	4c. C	N/A	
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v. Ye <i>ar</i>)	•	lace (State or Foreign try)
A.	Director		219-10-9132	M 2⊠F 83	Yrs.	Wiontins Days	Tiodis Willi.	Sept 1			yland
	land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loca	ition				10	0d. Inside City Limits
	e Man la-f sh tiffed	ctor	Maryland Baltimon	re		Hale	thorpe				1 ☐ Yes 2 🛣 No
	with th	Director	10e. Street and Number 3310 Bens	son Avenue		10f. Zip Code	21227		10g. Citize	en of What Coun ▲	try?
	death ms 23	Funeral		Was Decedent Ever in U Armed Forces?	.S. 13. W	as Decedent of H	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No		4. Race - Americ Black, White,	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		JYes 2∭X No	Specify:	o i noan, oto.,		Procific	ite
-00036	2 hour		15. Decedent's Educ	ation	16a. Decede	nt's Usual Occup	ation		16b. Kind	d of Business/Inc	
א	ithin 7: ne. nan "n Medi	Completed	(Specify only highest grade	College (1-4or 5+)			during most of wor i)	king	Hous	sewife &	Mother
7 0	filed w Hygier Ither th	Co	17. Father's Name (First, Middle, Last)	0	П	omemaker	18. Mother's Nam	ne (First, Middle,			
land	Aental rked o	To Be		Elmer	Neudecl	ker	Ida Mo	cNamara			
Mary	2 short and h		19a, Informant's Name/Relationship (Typ			,	and Number or Ru		-	-	Code)
e,	1 and Health tem 27		Charlene Weigman 20a. Method of Disposition	(Daughter)	Place of Disposit	tion (Name of	s Lane, E	Date Date		ation - City or To	own, State
aitimor	Pages ient of nt: If it		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		atorý or other plac n Mem Pk		/08	Glen	Burnie,	Maryland
מוב	permit. Departm Importa any Inju		21. Signature of Front Strice License	e Kevin E Eck	er Mc(Name and Addre	ss of Facility Lyniak Fu	ıneral H	ome,	P.A.	
	20 = 60		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat	130	E For	t Ave. I	Baltimor	e. Mo		Approximate Interval Between
8 1	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.	Shork	/					Onset and Death
1	/Medical Examiner		resulting in death)	Du to (or as a conseq	uence of):	1. 1000	n 1 - 1	1011.1	1.11	,	
	LXammer	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	De to (or as a conseq	uence of):	CXTREI	nity (.c/Iu/	1713	5	
	cuted nd ransit	Examine	that initiated events	Diabetes	Me 11	itus					
Ď,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
08/PU	ficate I physics the t	edical	d								
X Q Q	th certi rending ruse a	Physician/Me	23b. Was decedent pregnant	3c. If yes, outcome pf pregna 1□Live birth 2□Feta		Ectopic pregnanc	v		2	3d. Date of delive	ery Dav Year
П	ne dea the att	ysici	in the past 12,mmfins? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of o 9□Unknown		Other (specify)				WOTH	Day Toal
, ,	w requires that the death certific been signed by the attending f should be detached for use as	by Ph	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the unc	derlying cause giv	en in Part I.	23e. Did (obacco us	se contribute to the	he cause of death?
Hecords	equire; en sig ould be	ted b	Peripheral Vas	cular pre	sease			1 🗆	Yes 2□	No 3 ☐ Prob	pably 4 Donknown
éc C	. 0 -	Completed						24a. Was auto		24b. Were auto prior to co death?	ppsy findings available mpletion of cause of
	slcian: The law certificate has t irector, page 2 s		25. Was case referred to medical				26. Place of Dea	₩ Yes	2□No	1 ☐ Yes	2 /2 No
5	rysicia iis cert directe	To Be	examiner?	lospital: 1 Inpatient 2] ER/Outpatient	3□ DOA Oth	or:			□Other (Specif	fy)
n or	After th	cation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wor M 1	ryat rk? Yes 2 ⊡ No	28d. Describe	how injury	occurred	
UNISION	Attend death octor: /	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At h	ome, farm, stree		res 2 INO	28f. Location (Street and	Number or Rura	al Route Number,
$\frac{2}{7}$	tal or / s after al Dire ed in b	Certific	4 ☐ Homicide determined	building, etc. (Speci	<i>ty)</i>			City or To	wn, State)		
)\ `	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical (29a. Certifier 1 ☐ Certifying Physical (Check only one)	sician: To the best of my knowner: On the basis of examinated and manner stated.	owledge, death ation and/or inve	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as s place, and due t	stated. o the cause(s)
	To the vithin 2	Mec	29b. Signature and title of confiner	//		29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
)			1 Cay	V M.D	T	80	1014		41	2/08	
			30. Name and address of person who co	empleted cause of death (Itel	m 23a) (Type, P	rint) N	meula	rá Grt	nor	10 LL	repital)
	Sta	ite	31. Date filed (Month, Day, Year)	22. Registrar's Sign	ature		arcy wi	ye on	11/1/	ic / Th	19.100

NK UNK	1- For State	ate of Maryland		ment of I licate of I		and	Menta	ıl Hyg		Reg. No	20		107
Physician/	Registrar 1. Decedent's Name (First, Midd	le,Last)							Date of De	eath	Year	3. Time of De	1
rifysiciani rifysiciani ral Examiner	Lance Deshir							1	Month March 18		8	1100 hrs	3
	4a. Facility Name (if not institution		r)	46	. City, Tow	n, or Lo	cation of I	Death		4	c. County of Dea	ath	
	3600 Block E. Monun	nent Street			Baltimo	re							
Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. last	birthday)	If Under 1		If Under 2		B. Date of E	Birth (MN	//DD/YYYY) 9. E	Birthplace (State eign	or
Director	218-86-4725	1X M 2 F	33	Yrs.	Months	Days	Hours	Min.	Aug 2	9, 1	.974	CountryMary.	land
	Usual Residence of Decedent												
any	10a. State 10b. County		10c. City, To	wn or Locatio	n							10d. Inside C	
	MD		F	Baltimo	ore							1 X Yes	2No
Maryland Aaryland 1 at once.	10e. Street and Number				10f. Zip Co	ode		u:	nk	10g. Ci	itizen of What Co	ountry?	
5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Completed by Funeral Director	7506 Brooksio	le Avenue		1	·						USA		
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r death with or items 23 must be no	11. Marital Status 1 X Never Married 2 N	12. Was Decede Armed Force		13. Was	s, specify (Cuban, I	Mexican, F	Puerto Ri	can, etc.)	140-	White, etc		,
or its		1 Yes	2 X No		v o 🕏	٦	annoife a				Specify:	white	l
s after ral", by F		ivorced If Yes, Give Year or Dates:		6a. Decedent	Yes 2 X			ad of wo	rk done	116h	. Kind of Busines		
yatur Xam	15. Decedent's Education (Sp.			during mo	st of worki	ng life. E	OO NOT u	se retire	d)	100	. rand or Eddinion		ļ
eal F	Elementary/Secondary (0-12		or 5+)								ustom p	aintino	İ
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner Completed by 1	9	0		pai	nter	. [40	Mother's	Name (Firet Middl		en Surname)	aincing	
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MD 21215-0036 to 2 should be filed within 721 than Mental Hygiene. In 27 is marked other than aumatic event, the Medical To Be Comple				405 Mailine	Addross	/Ctroot				dumber	City or Town, St	tate Zip Code)	
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Page ent o nt:]	4 Donation 5 X Other												
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traus	21 Signatur of Funeral Service	ce L ns	ecto_	22. N	lame and A	ddress	of Facility	oard	655	W 1	Raltimon	re Stree	+
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Physician	23a. Part I. Enter the 1/2 ease, of ture. List only one caus	or mple tions that caus	ed the death. I	Do not enter th	ne mode of	dying, s	such as ca	rdiac or	respiratory	arrest, s	shock, or heart	Between	Onset and
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x 6 h cer itendi	past 12 months:		t at time of dea	ith 5 0	ther (Spec	fy)				-			
). Box 68761 the death certificate by the attending phy ched for use as the tellowed for use as the te	1 Yes 2 No 9 L	Unknown g Unknow					to an in De		23a F	id tobac	co use contribut	te to the cause or	f death?
Division of Vital Records, P.O. Box 6876(tal or Attending Physician: The law requires that the death certificate all Directors. After this certificate has been signed by the attending physeled in by the funeral director, page 2 should be detached for use as the beat the backfillow. To Be Commissed by Physician/Ma		ditions contributing to d	eath but not res	sulting in the	underlying	cause g	iven in Pa	11 (1.			2 V No 3		Unknown
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Sio	2 Accident In	vestigation 28e Place	of Injury - At ho	me, farm, stre	et, factory	office b	ouilding, et	tc.	28f. Locat	ion (Stre	et and Number	or Rural Route N	lumber, City
Division o ospital or Attending hours after death meral Director: Aft y filled in by the fune	3 Suicide 6 X C	ould not be	Found in						Baltim	wn, State OCC,	e) Bood bik	or Rural Route N C. E. Monu	ment St.
bou hou		. The she hast	of my knowlode	no death occi	irred at the	time. da	ate and pla	ace, and	due to the	cause(s	s) and manner as	s stated.	
	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the basis of	examination ar	nd/or investiga	ation, in my	opinion	, death oc	ccurred a	t the time,	date and	d place, and due	to the cause(s)	
To the within 2 To the complete	29b. Signature and title of cer	/ and manner sta	ted.				e number					(Month, Day, Ye	ear)
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OCME	30. Name and addr s. of pe		of death (Item	23a) niner 11	I1 Penn	Street	t. Baltim	nore M	ID 2120	1			
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Stat Registra	HER !!	7 2008 Free	istrar a Signaru	Lon	ARD I								

08-02238 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephen A. Duvall State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day March 21, 2008 Medical Examiner 0013 hrs Stephen A. Duvall 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Johns Hopkins Bayview Medical Center Raltimore 9. Birthplace (State or Foreign Country) unk 5. Social Security Number unk6. Sex If Under 1 Year If Under 24Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) Months Days Hours Director Mar 31, 1963 1 X M 2 F Yrs Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD "natural", or items 23a or 28a-f show Baltimore 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country 515 E. 23rd Street 21218 USA Funeral 11. Marital Status 12. Was Decedent Ever in Ալբիդ k 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, unk Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 Divorced Yes, Give Year Widowed Yes 2 X No specify: black Specify: 2 16a. Decedent's Usual Occupation (Give kind of work donern k during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 traumatic event, the Medical than filed within unk other (17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk permit. Pages I and 2 should be file Department of Health and Mental H Important: If Item 27 is marked of Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State rtant: If its crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. i fure o Superal Service Licensee Ron 1 Baltimore, MD 21201 se, or complications art I. Enter the lise: fat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ure. List only on cause on each line. een Onset and /Medical Death a Complications of Chronic Narcotism Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - tran Physician/Medical AMENDED 23a, 27 per ME g878 4/10/08 amh X UNPENDED The law requires that the death certificate be Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, has been 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate Yes 2 V No 1 Yes 2 No 25. Was case referred to medical the Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? this 1 V Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Other ဥ 1 🗸 Yes No After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural Pending Yes 2 No within 24 hours after death. To the Funeral Director: 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) (Specify) 4 Homicide 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 21, 2008 west 30. Name and address of person who completed cause of death (Item 23a)

State

Registrar

Ana Rubio MD.

31. Date filed (Month, Day, Year)

APR 0

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death April 4, ^{Day} 2008 **Physician** 1:21 A M James William Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 16, 5. Social Security Number 9. Birthplace (State or Foreign Sex 14 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Illinois 1938 349-30-4019 70 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location the Marylan 10a State 28a-f shov items 23a or 28a-f shore 1 ☐ Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 9525 Long View Drive 21042 Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 Never Married Married Baltimore, Maryland 21215-0036 traumatic event, the Medical Exami ō If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clergyman Religious Order 12 should be filed w h and Mental Hygier 7 is marked other tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leona Martha Krugler James Ivan Davis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other tr once. 9525 Long View Rd. Ellicott City, MD 21042 Elizabeth Susan Davis/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 04/05/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a, Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a nonsequence of). Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 1No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier I ☑ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of Pertifier 29d. Date signed (Month, Day, Year)

Hary 4, 2008

State Registrar

gistrar's Signature 31. Date filed (Month, Day, Year) APR 0 7 2008

670, N. Chalsoft, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month RIL Day 3 Physici<u>an</u> Z 27 21 8 26:54PM CHARLES SUMNER DAWSON /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Apr 14, 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F 169-16-5880 85 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 Tyes 2 No Director Maryland Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 29 Parliament Court 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WW] If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacutical Corp. <u>Sales Representative</u> permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 Is marked other I any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Sumner Dawson, Sr. Henrietta Scheibal 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 61836 Dart Creek Road, St. Helens, Oregon 97051 Anne D. Christensen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 4/5/2008 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signa Avol Fune al Service Cice of Awar 22 Name and Address of Facility FUNERAL HOME, INC Martin D. Lawson 6500 York Road, Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIA INFARCTION Physician /Medical Due to (or as a consequence of): Examiner ARTERISCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-trar Due to (or as a consequence of): attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 10 Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 □ No 9□Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an page 2 s autopsy performed certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this e Hospital or Attending Ph 24 hours after death. e Funeral Director; After th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

10

Maryland 21215-0036

Baltimore,

Records, P.O. Box 68760,

Division or Vital

State Registrar

GAIL CUNNINGHAM, 31. Date filed (Month, Day, Year) 7 2008

30. Name in address of person who completed couse of death (Item 23a) (Type, Print)





D39215

TOWSON. MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Ethel Virginia Darling 2008 April 10:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 9140 Liberty Road Randallstown 8. Date of Birth (Month, Day, Year)
Oct. 18, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2XX 213-20-6256 84 1923 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☑ No Baltimore Randallstown Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 United States 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must be 9140 Liberty Road Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
nt: If Item 27 Is marked other than "natural", or Items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2XXNo
If Yes, Give
Year or Dates: 1 Never Married XX Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Textile Mill 12th Weaver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Reeder Clarence Higgs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9140 Liberty Road Randallstown, MD William D. Darling Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of Important: If Its
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery April 8, 2008 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Burrier-Oueen Funeral Home & Crematory, PA

1212 W. Old Liberty Road Winfield, MD, 21784

23a. Print. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

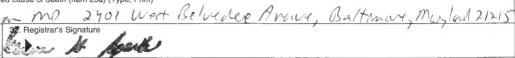
Approximate 22. Name and Address of Facilify Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director After this certificate has been signed by the attending physician and stell in by the funeral director, page 2 should be detached for use as the hundarmant Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner-of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 022782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2) Q

State 31. Date filed (Month, Day, Year)
Registrar APR 0 7 2008



08-02502 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Rodney W. Davis 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1025 hrs March 30, 2008 Medical Examiner Rodney W. Davis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A 11 W. 20th St. Apt. 11 P If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7, Age (In yrs, last birthday) **Funeral** Foreign Country)MD Months Days Hours Min 11/6/65 Director 216-86-9152 42 Yrs 1 XM 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10h. County 10a State 1 Yes 2 No MD N/A 28a-f show Baltimore notified at once. Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 3602 W. Lexington St. 21229 USA 23a with Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Pages I and 2 should be filed within 72 hours after death winent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be. White, etc. African Armed Forces? 1 XNever Married 2 Married Yes Specify: American Yes 2 X No specify: Give Yea 3 Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Automobile Baltimore, MD 21215-0036 Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia L. Wilson Be William Nathaniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3602 W. Lexington St., Balt., MD 21229 Virginia Easley/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4/8/08 Balt., MD Department of Important: I injury or othe Bayview Crematory Donation 5 Other Specify 22. Name and Address of Facility Hari P. 21. Signature of Funeral Service L Close F.Svs, PA .MD 21206-5105 5126 Belair Rd.Balt. Approximate Interval 23a, Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. METHADONE AND ETHANOL INTOXICATION /Medical Death Immediate Cause (Final disease ANE COCATNE USE xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician for use as the burial -Box 68760, 23d, Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be examiner? Other₄ Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 After this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: found at 1 Natural Pending 1 Yes XX No UNKNOWN Director: d in by the f found 3-30-08 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 XX Could not be determined or Town, State)
W. 20th St., Suicide FOUND IN DWELLING (Specify) Apt. 11P To the Funeral Homicide the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Maryland 29a. Certifier 1 Certifying Physician:

OCAL

Medical

State

29b. Signature and title of pertifie

Mary G. Ripple MD.

31. Date filed (Month, Day, Year)

and manner stated

Deputy Chief Medical Examiner

2000

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2008

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 31, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 amron /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Futu North Point If Under 24 Hmore are Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Min. 2/9-/8-2779 Usual Residence of Decedent 3 Yrs. Director 10d Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Show the Medical Examiner must be notified at 1 Pres 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö U.S. 21222 or items 23a 224 HVENGLE 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 Mo If Yes, Give Year or Dates: 1 Neyer Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) other t permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other eny injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nemzek Lugar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road, Perry Hall M 1/2.

Date 24. Location - City or Town, State 20b. Place of Disposition (Name of olberi loppa 20a. Method of Disposition cemetery, crematory 1 Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LOWY Cemelery 22. Name and Address of Facility Facility Bradley-ASK 21.34 W. 110W Spr. 21. Signature of Funesal Service Licensee Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEMEN TDA Physician /Medical Due to (or aska consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 38 IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ţ in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe ZU No 2- No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No 4 Viursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1, 2008 April Sylvia B. Erwin 6:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5310 Locust Avenue Bethesda Montgomery if Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)

January 5, 1918 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🔀 F 90 234-18-7848 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5310 Locust Avenue 20814 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No if Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. Be Completed by 3K Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Volunteer White House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Troy Alfred Burns Pearl Abbot 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina D. Erwin/ Daughter in Law 18 Lake Helix Drive, La Mesa, California 91941 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington
National Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 29, 2008 4 □ Donation 5 □ Other (Specify) Arlington, Virginia 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase. Inc. 755/ Wisconsin Avenue M00335 Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Stage Kidney Disease disease or condition resulting in death) 3 Months Due to (or as a consequence of): End Stage Heart Failure 13 Months Sequentially list conditions, if any, leading to influential cause. Enter Underlying Cause (Disease or injury Directo (unas a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, Atrial Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2X No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Funeral

Director

show

r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

Pages 1 and 2 should be filed wi tent of Health and Mental Hygien nt: If item 27 is marked other th ry or other traumatic event, the

permit. Pages 1
Department of H
Important: If iter
any injury or ott

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

nding physician and use as the burial-transit signed by the a page 2 should certificate director

this

The law requires that the death certificate be or Attending Physician: funeral After 1 death. nours after death.
neral Director: #

Division or Vital Records, P.O. Box 68760,

27. Manner of Death 1 Natural

29a Certifier

(Check only one)

29b. Signature and title of certifier

ò Completed Be Certification: To

5 Pending investigation 2 Accident 6 Could not be 3 Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

and manner stated.

Injury

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

M.D. 8901 Wisconsin Avenue, Building 10 Bethesda, Maryland 20889

tem 23a) (Type, Print) 30. Name and address of person who completed cause of death

VA 010123018

29c. License number

April 1, 2008

29d. Date signed (Month, Day, Year)

20 State Registrar

completely

Medical

To the Hospital or within 24 hours aft To the Funeral Di

31. Date filed (Month, Day, Year) APR 0 7 2008

Alexander Bustamante,

32 Registrar's Signature

DHMH 17 Rev 1/2001

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			1- For Amend Items Registrar	23a, 25, 28a	f per me	12877,03, dificate of	/26/08dhi Death	Re	g. No.	
	Dhysio	an	1. Decedent's Name (First, Middle, La	st)				2 Date of Death Month	n Day Year	3. Time of Death
	Physici /Medi		Dr. Stanley A. F	ishbein				March 2		1:05 AM M
	Examir		4a. Facility Name (If not institution, giv	e street and number)			or Location of Dea	th	4c. County of Dea	th
			604 Dunkirk Road				imore		Baltimo	re
	Funeral Director		5. Social Security Number 6. S 212–36–9136	ex 7. Age (la ☑M 2□F 6	n yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1940 Man	thplace (State or Foreign ountry) 'yland
	and and		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Many f sh	ō	MD Baltimo	re	Ralt	imore				1 ☐ Yes 2 ☑ No
	28e	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	puntry?
	3a o	Funeral Director	604 Dunkirk Road			21	212		USA	.,
	death	Jer	11. Marital Status	12. Was Decedent Eve	r in U.S. 13. \	Was Decedent of H	Hispanic Origin? (Specify Yes or No- to Rican, etc.)	14. Race - Ame	erican Indian,
21215-0036	d within 72 hours after death with the Maryland itene. Itene. r than "naturel", or Iteme 23a or 28e-f show the Modical Examinar must be notified at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 A Yes 2 No If Yes, Give Year or Dates: 5		f Yes, specify Cub 1 ☐ Yes 2∑∏ No		to Rican, etc.)	Specify: wh	
20	72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Deced	dent's Usual Docup	pation	erting 1	6b. Kind of Business	/Industry
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Maryland	d is b	Be	17. Father's Name (First, Middle, Last,					me (First, Middle, M	,	
3	should bind Ment	우	Marshall Nathan					Lee Roth		
Jai	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Name/Relationship (City or Town, State,	Zip Code)
	s 1 and if Healti Item 27 other 1		Susan Fishbein/sp		604 20b. Place of Dispo		Road Bal	timore, M		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specif.	Removal from State	cemetery, cren	natory or other plac	ce)	Date 2	Oc. Location - City or	Town, State
Ball	permit. Page Department Important: If eny injury or once.		21. Signature of Euneral Source Licer	Wede virge		Name and Addre ate Anat			Baltimore	Street
ı			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a co		7 0.07 10	11/1	1 13/2 (3 /3		HALEAREAN
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9	a o a		IF FEMALE:							
Вох	that the death cer ed by the attendir detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1☐Live birth 2 ☐		Ectopic pregnancy	,		23d. Date of de Month	
<u>.</u>	ne de the a hed f	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify) _			Month	Day Year
P.O.	hat the d by detac	P		antabutian to dooth but a		4.4		OG- Bitter		
ords,	w requires that the been signed by th should be detache	ted by	Part II. Other significant conditions o	untributing to death but no	or resulting in the un	grand cause giv	en in Part I.	1 Tyes	acco use contribute to 3	othe cause of death? obably 4 Unknown
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<u>ita</u>	icien: Th certificete ector, peç	Be C	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2 ath (Check only one	•	2□ No
>	S S D	ToE	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 DOA Oth	05		nce 6 ☐Other (Spe	cifv)
ı of	ding Ph th. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Injur Wor		28d. Describe how	v injury occurred	AuxED I ARGE
Division	Attending r death. ector: After by the fune	atic	1 Katural 5 ☐ Pending 2 ☐ Accident investigation	10/04/200	20		Yes 2 140	Minery of	CEDENT	- THIMILES
<u>≅</u>	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	et, factory, office			eet and Number or Ru	ıral Route Number,
	rs aft	Cer		HOME				2 DUNNIRK	0-15	KYLAND 21212
	houn uner uner	edicai	29a. Certifier 1 Certifying Ph	ysician: To the best of miner: On the basis of exa	y knowledge, death	occurred at the tin	ne, date and place	, and due to the cau	use(s) and manner as	stated.
	the Print 24 the Print Plets	ed		and manner stated.		estigation, in my o	pirilon, death occi	med at the time, dat	e and place, and due	to the cause(s)
	To the Hospital or Attendinwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	D Do		29c. Licens		29	d. Date signed (Mont	
•			· allhut fo	hn Klito		Doo	51021		03/07/2	800
	8		30. Name and address of person who							
	U		ALBERT JOHN PULI		301 SAINT	PAUL PLA	CE BA	LTIMURE,	MARYLAND	21202
	Sta	te ar	31. Date filed (Month, Day, Year) MAR 2. 6 2003	2. Registrar's	Signature	00 0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23a, 25, 27 per me, 2878, 04/03/08dhb Registrar Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOLI Ollunbica If Under 24 Hrs. 8. D 8. Date of Birth (Month, Day, Year) Age (In yrs. last f Under 1 Year 9. Birthplace (Sta **Funeral** Country) 1□м ЖЖР Days Min. 57 May 24, NY 081-38-1093 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Meckel Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 5659 Lightspun Lane 21045 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5 Elementary/Secondary (0-12) CLnical Psychologist Private Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Neil Fiske Lorrine Lawson P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neil Fiske (Father) 307 S. Williams Road Blossburg, PA 16912 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State All County Cremation 3/12/2008 Sykesville, MD 4 Donation 5 Dother (Specify) 22 Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A. (Box 195)
Sykesville, MD 21784 21. Signature of Funeral Service Licenses Duan L. Haight Funeral Home & Chapet Sykesville, MD 21784

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Coronary Artery Immediate Cause (Final disease or condition resulting in death) Physician Disease /Medical Due to (or as a consequence of) **Examiner** CATTON APPROVED BY MEDICAL EXAMPLES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner and i-transit The law requires that the death certificate be executed Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death in the past 12 months? Month Day Year P.O. I 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 ☐ Probably 1 🗌 Yes 4 ☐Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy performed this certifice te 1∐ Yes 2 ∏ No Division or Vital or Attending Physician: 25. Was case eferred to medical examiner?

Yes 2 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA P funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending within 24 hours after used.

To the Funeral Director: After a property of the further filled in by the further further for the further for the further for the further for the further 1 ☐ Yes 2 ☐ No investigation 2 Accident uld not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

State Registrar err

2008

31. Date filed (Month, Day, Year)

APR 03

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Elise В. Faltot 11:42 AM 2008 /Medical 4c. County of Death wn, or Location of Death Facility Name (If not institution, give street and number) Examiner Boltimore usedale in Square Date of Birth (Month, Day, June 3 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) Social Security Number Funeral Months 1□M 2₩F 89 W٧ 236-14-9858 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County a or 28a-f show be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 USA Items 23a cliner must be 8800 Walther Blvd. # 2516 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 1 No 1 ☐ Never Married 2 Married ☐ Yes 2 Yes, Give White 1 □ Yes 2 🖾 No Specify: 215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education the Teacher 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) and Mental I Alton Brannon Armstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once. 8800 Walther Blvd. # 2516, Clovis Faltot (husband) Parkville, MD. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Gran. 04/09/08 Timonium, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Pak1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SCVI Monthe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy perform death? 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t al or Attending F s after death. Il Director: After ed in by the funera Certification: (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8700

Jeff Landsman

Nalther

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician MARCH 2230pm ELSBETH 528 5008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Chestertown Queen Anne 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🔀 F Yrs. 80 Director 215-40-8494 05-04-1927 Germany Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 TYes 2 XINO Director MD Oueen Anne Centreville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö Pages 1 and 2 should be filed within 72 hours after death with 255 Opera Court 21617 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ð 3 Widowed 4 □ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +2 Sales Retail Department of Health and Mental Hygin Important: If item 27 Is marked other any Injury or other traumatic event, the once, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Elseeth Ziesche 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Cavalry Court, Centreville, MD 21617 Mike Francis -Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State March 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 31, 2008 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M01378 MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Adenocarcinoma **Physician** 4 Thouths disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ GERD: Arthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after common to the Funeral Director: Aft

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Medical

29a. Certifier

31. Date filed (Month

BrownSt

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chestartown MD

State Registrar PR 0 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMIND TITH#9, perFff, 6878, 4/14/08, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2008 Year **Physician** April 1, 9:00 P M Betty Lou Farley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel 68 Foxwell Bend Road 9. Birthplece (State or Foreign Date of Birth (Month, Day, Year)
Nov 17, 1 If Under 1 Year | If Under 24 Hrs. | 8. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 🔀 F 1939 68 Director 220-40-7275 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a State 10b. County 1 ☐ Yes 2X No Director Glen Burnie Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 68 Foxwell Bend Road 21061 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify. ģ White 3 Widowed 4 Divorced 'naturai". Hygiene. other than "natura ent, the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hair Care Cosmetologist 77 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry Merson Gertrude Mae Merson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and important: If item 27 is m any injury or other traum Mark D. Farley - spouse 68 Foxwell Bend Road, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 1 Burial 2 □ Cremation 3 □ Removal from State 7, 2008 Elkridge, MD 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Pk. 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature Funeral Service Licenses M00053 MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 tou Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) years **Physician** breast cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami Division or Vital Records, P.O. Box 68760, physician and s the burial-trans Due to (or as a consequence of) by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21XNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl on Be Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Xo 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of De nh 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined after 4 ☐ Homicide within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nue ven, MD 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) W 900 Best gate Road #300 Annes IS, MD UYO werner, MD State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year April 3, 2008 1:10 A M Geraldine Ferrell 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 1 □ M 2 💢 F 69 214-52-6153 March 25, 1939 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐ No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13808 Arctic Ave. 20853 United States 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Cochran Evelyn Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13808 Arctic Ave., Rockville, MD 20853 <u> Edward Adam Stonestreet/Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition April 7, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVATION CATCINOMATOSS TESTETIC month Due to (or as a consequence of) most OVATIAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ueaur 1 ∐Yes 2 ∐No 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical **Examiner** Examine

permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturany Injury or other traumatic event, the Medical.

Baltimore,

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Records.

Vital

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Division

RALDIN

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Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Physician/Medical

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Completed

Certification: To

Medical

N √ Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

attending pl director, p.ge 2:

Hospital or Attending To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

0 Registrar

State

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

29c. License number

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\$316 Democracy Blud., Bethesda, MD 20817 Michael Emmer, M.D.,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

82 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** MARY HELEN FRAZIER DQIA AM 2008 03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL HIOMICO Salistill CIMY If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 22,1938 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Min. 245-52-0604 70 Director North Carolina Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 7933 Central Avenue U.S.A. 21122 r than "natural", or Items 23a the Medical Examiner must t Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Sears Roebuck & Co. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Be George W. Holler S. ဥ Winnie Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trau Carlton Allen Frazier Jr. (Son) 7933 Central Avenue, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □Removal from State Glen Haven Mem. Park | 04-07-08 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ther I Service Li x 1869 McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 xuni Francis S. Karczmarek M00331 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CALDIOMYOFATHY YEARS /Medical Due to (or as a consequence of): Examiner AD YEARS Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine ESRD physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 I Inknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 1 Tyes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has 1□ Yes 2 100 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After this funeral 27. Manne Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Latural Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 5 To the Hospital o 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 08

State Registrar

DHMH 17 Rev 1/2001

Tomasz Andrrzel 31. Date filed (Month, Day, Year) APR 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Swierkosz

32. Registrar's Signature

400 Eastern Shore Drive Salisbury, MD. 21804

			1 - For State Registrar	State of	Maryland		artmen				lental Hy	giene Rag. No.	008	11086
			Decedent's Name (First, Middle, Last,)	,						2. Date of Dea	ath		3. Time of Death
	Physici /Medi		Baby Boy Galloway	7							March	30, 20	008 ^{Year}	11:05 AMM
) *:	Examir		4a. Facility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location o	of Death			ounty of Dea	
			Fort Washington H	lospital	-		Fort	: Was	hing	ton		Pr	ince G	eorge's
F	Funeral Director		5. Social Security Number 6. Security Number 1 D	x 7 Дм 2□F	. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	Hours	24 Hrs. Min. 5	8. Date of Birt (Month, Day Mar 30	h y, Ye <i>ar)</i> • 200	9. Bir Co Mar	thplace (State or Foreign ountry) Yland
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c Cibe	, Town or Lo	antion							10d. Inside City Limits
	lanyla eho	5		1 .										1 ☐ Yes 2 ☐ No
	28a-f	ect	MD Prince Ge	eorge s	Te	mple H	111S	Code				10= Cities	n of What Co	A
	with with	급	2911 Brinkley Road	1 #102			101. Zip		20748	2		rog. Citize	USA	ountry :
	leath	by Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.S	S. 13 V	Was Decer				ecify Yes or No	. 14		erican Indian,
10	fter d	표	1 Never Married 2 Married	Armed Ford	es?				n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		Black, Whit	te, etc.
3	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dat			1 ☐ Yes	2 X No	Specify:			Sį	pecify: b1	Lack
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ehow raumatic event, the Medical Examinet must be notified at	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	ient's Usua	Occupa	tion	t of worki		16b. Kind	of Business	/Industry
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21	ygien ygien t, th	S		one			infan	t					fant	
pu	tai H d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden Su	ımame)	
<u>\sqr</u>	Men Marke Marke	ို	Tarshia Leigh Gal								11oway			
Maryland	and rem		19a. Informant's Name/Relationship (Ty Fort Washington H								I Route Numbe			
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 23 is marked other than "natural", or Items 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition	Ospitai		1 / 1 ace of Dispo			ton		Fort Wa			MD 20744 Town, State
Baltimore,	Page nent c ant: If ary or		1 Burial 2 Cremation 3 P 4 Donation 5 Other (Specify)		ate Jose	emetery, cren	natory or o	ther place	9)		, d. to	200. 2002	don's City of	TOWN, State
Balt	Departi Departi Importa any inj		21. Signature of Funeral Service Licens Ronald S.	vade I	rector	_ St	Name an ate A	Inato	omy Bo	oard 2120	655 W.	Ba1t	imore	Street
			23a. Part . Enter the disease, ir com- shock or heart failure. List only or	ications that car	used the death	. Do not ente	er the mod	e of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
1	Physician	3	Immediate Suse (Final disease or condition	/		. 4							20	Onset and Death
1	/Medical		resulting in death)	Due to (o	as a consequ	ence of): /	1616	70	MA E	2//	m 21	over	763	
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	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	as a consequ	ence of):								
	The law requires that the death certificate be executed tile hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
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876	ate b physic the b	dica		d										
9 ×	it the death certific by the attending p tached for use as is	Physician/Medical	IF FEMALE:	120 14										
Вох	attenc attenc for us	ian	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal	death 3	Ectopic pr					230	 Date of de Month 	livery Day Year
o	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov	nt at time of de m	iatn 5∟	Other (sp	өспу)						
P.0	that the the the the the the the the the th		Part II. Other significant conditions cor	ntributing to dea	th but not resu	Iting in the ur	nderlying c	ause give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
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ā		ပိ	25. Was case referred to medical						00 PI		1 ☐ Yes	100	1 🗆 Yes	3 2 □ No
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o i		-1	27. Manner of Death	28a. Date of (Month,		28b. Time of		8c. Injury Work			ne 5 ☐ Resid 28d. Describe h			icity)
Ö	oftin oftin oftin	# S	1.☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	м		? ′es 2 🗆 l	No				
Division	Attendi ar death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place o	f Injury - At hor	me, farm, str	et, factory	, office		:			Number or R	ural Route Number,
۵	s after and or a	Cert	4 Li Hollinedo	building	, etc. (Specify	/					City or Tow	m, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Completely filled in by the fune	edicai	29a. Certifier 1 Certifying Physical Example 2001	sician: To the b	est of my know	vledge, death	occurred	at the tim	e, date an	d place, a	and due to the	cause(s) an	nd manner a:	s stated.
	the H the F the F		Une)	and manne	r stated.					un occurre				
R 3	오 를 오 등	Σ	29b. Signature and title of certifier				- 1	. License					-	th, Day, Year)
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			30. Name and address of person who co	empleted cause	of death (Item	23a) (Type,	Print)			-		- /.		,
	-0		Junes Mitches 31. Date filed (Month, Day, Year)	1 39 Bay	ustrar's Signat	117	//	100-	9510.	nK	a. F	wth	Sti Show	08 ngton MD 20744
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			Registrar 1. Decedent's Name (First, Middle, Last)		,	Cei	rillicate of	Deam	2. Date of De	Reg. No.	200	8	3. Time of Death
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/Me Exan		-	4a. Facility Name (If not institution, give stree	and number)			4b. City, Town, o		ath		County of I	Death	
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Funer Directe			5. Social Security Number 6. Sex 1 M		e (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		v Year)	1010	Country [Aary]	
and		-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	ecation					10d	. Inside City Limits
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Saltimore Permit. Pages 1 Department of H mportant: If Ite iny Injury or ot			20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	/al from State		Red	osition (Name of matory or other place eemer Cem	n. 20	iľ 11, 08	Bal	timore	e, Ma	aryland
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To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		Physician/Me	in the past 12 months?		pf pregnancy 2 ☐ Fetal dea t time of death		□Ectopic pregnanc □ Other (specify)	у			23d. Date o Month		ay Year
requires that the een signed by the nould be detached		by Ph	Part II. Other significant conditions contribu					ven in Part I.	23e. Did t	tobacco	use contribu	ite to the	cause of death?
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			For State	State of Mar	-	rtment of H rtificate of I			giene 2 () Reg. No.	08	1108	8
4	, di 19		Registrar Decedent's Name (First, Middle, La	st)]	2. Date of Dea	ath		3. Time of Death	_
	ysicia Medic	-	Dorothy Marion	Gutridge				Month April	Day 1. 2008	Year	4:15 PM	
	amin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	110-1-1	4c. County	of Death		
		*	101 Center Place			Dundalk	.		Balt			
Fun Dire	eral ctor		5. Social Security Number 6. S 215-22-3256 Usual Residence of Decedent	Sex 7. Age (I 1 □ M 2 1	In yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11/21/	, Year)	9. Birthp Coun M		7
/land	at		10a. State 10b. County	10	0c. City, Town or Loc	cation				1	0d. Inside City Limits	
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s 1 and 2 should be filed within 72 hours after death with the Maryland them 21 and 2 should be filed within 72 hours after death with the Maryland them 27 is marked other than "natural", or items 23a or 28a-f show	raminer r	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🔀 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Blac	ok, White,		
2 hour	calE		15. Decedent's E	ducation	16a. Deced	lent's Usual Occup	ation	I	16b. Kind of Bi			
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should nd Me mark	imatic	2	Charles 19a. Informant's Name/Relationship		uhl 19b. Mailin	g Address (Street a	Margare			Appel State, Zip	Code)	
2 분명 출	r trau		Catherine Sanford	l (Step Daug			Forest D				21219	
			20a. Method of Disposition 1 XBurial 2 Cremation 3		20b. Place of Dispos		; [Date	20c. Location -			
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permit. Page Department of Important: If	ny Inj		21. Stanature of Funeral Service Lice	nsee OO	22	. Name and Addres	F TT 2003		Funeral	•		
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The law requires that the death certificate to the has been signed by the attending physic	ched for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 [4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	lEctopic pregnancy l Other (specify)	,			te of delive onth	ery Day Year	
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hysic this ce	al dire	To	1 Yes 2 No	Hospital: 1 Inpatient			4 LI Nursing Ho	me 5 Resid	lence 6 □Oth	er (Specif	y)	
ding P	nner	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Injun Worl		28d. Describe h	low injury occur	red		
ttend death ctor:	y the 1	icat	2 ☐ Accident investigatio 3 ☐ Sulcide 6 ☐ Could not b	e 290 Place of injuny	- At home, farm, stre		Yes 2□No	28f. Location /S	Street and Numb	ner or Rur	Il Route Number,	
after Dire	d ii b	Certification	4 ☐ Homicide determined	building, etc. (Specify)	,,,		City or Tow	n, State)	or or ridre	, riodio ridiniboli,	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	letely fille	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of r miner: On the basis of ex and manner stated	camination and/or inv	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the ored at the time,	cause(s) and madate and place,	anner as s and due to	tated. the cause(s)	
To the within 2	comp	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signe	d (Month,	Day, Year)	_
			David Sch	ren DO.		#43	234		APRIL	2,2	008	
1	7		29b. Signature and title of certifier David Livi 30. Name and address of person who DAVID S/LVE 31. Date filed (Month, Day, Year) APR 0 7 2008	RDO, 35	h (Item 23a) (Type, I	ern A	, Balt	smor-	e MD	21.	924	
Re	Sta gistra		31. Date filed (Month, Day, Year) APR 0 7 2008	32. Registrar's	Signature	e e	1		-			

08-02636 Alvin Gross

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death dent's Name (First, Middle,Last) Physician/ April 3, 2008 1214 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not Institution, give street and number) Baltimore Sinai Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Davs Hours Director 214.76.2932 1**X**M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ì 10a. State 10b. County Baltimore 1 X Yes 2 No or 28a-f show MD notified at once, it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland frinent of Health and Mental Hygiene. Transt: If item 27 is marked other than "matural", or items 23a or 23a-f she ry or other reammants event, the Medical Examiner must be notified at once y or other reammatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21201 4205 Chathan Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S 1 Never Married 2 Married 2 X No Yes Yes 2 No specify: Specify: If Yes, Give Year Divorced Widowed <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Entertainment MD 21215-0036 Musician 2th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) anes to Itom N. Gross, æ 19b. Mailing Address (Street and purpler or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2330 Goodhope Road Apt. 1212 Wash. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 2 Cremation 3 Removal from State 08/98 Greenmount Crematon Donation 5 Other Specify: 22. Name and Address of Fallity Vang 21. Signature of Funeral Service Licensee allahn andalstown MD 21133 Liberty Road Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and -List only one cause on each line. /Medical Death a. Thoracic Aortic Dissection Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions this certificate has been signed by I director, page 2 should be detach ģ Yes 2 No 3 Probably 4 ✔ Unknown Hypertension Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? No Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Other Nursing Home 5 Residence Inpatient 2 CER/Outpatient 3 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 V Natural Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director,

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

determined

Homicide

29b. Signature and title of certifier

29a. Certifier (Check only 1

Medical

State Registra

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

Pamela E. Southall, MD 31. Date filed (Month, 1997) 32

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

April 4, 2008

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 23a State of Maryland / Department of Health and Mental Hygiene per dr., 2878, 04/07/08dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Hobbs 08:05PM elores 03 22 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner - Ruxton Care Baltimore OWSON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Min. Months 217.34.4463 1 ☐ M 2 🔭 F Director 02/08 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notifled at N/A 1 XYes 2 No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number or items 23a or 6210 Park Heights Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Counselor 12thorade 17. Father's Nakoe (First, Middle, Last) Public Schools 5+ Years 18. Mother's Name (First, Middle, Maiden Surname) Be Evelun Lewis ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 6210 Park Heights Avenue #904 Baltimore MD 2125 permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trauonce. Hobbs Hw.band 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 ☐Removal from State Baltimore, MD 03/28/08 Arbutuo Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughn C. Greene Funeral Sensice aughn 8728 Liberty Road Randallstown MD 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or here railure. List only one cause on each line. Immediate Cause (Final 1 Day Cardiac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the burial-transi Hypertension that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perform After this certificate 1☐ Yes 2 X No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier D0059283 30. Name and a least of person who completed causes death (Item 23a) (Type, Print) Bellona Lame #216, Towson, MD 21204 4ddo M.D.

State Registrar DHMH 17 Rev 1/2001

ichan

31. Date filed (Month, Day, Year)

APR 0 7 2008

Soul .

Registrar's Signature

Jennifer Ann Hickman

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ennifer Ann Hid	1	- For State Certificate C		ygiene Reg. I	200	18 109
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
al Exami		Jenniter Ann Hickman		Month Da March 30, 20	008 4c. County of Deat	0532 hrs
		4a. Facility Name (if not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death Laurel		Prince Georg	i i
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth(MM/DD/YYYY) 9. Bi	
Director		353.66.600 10M 2XF 29 Y	Months Days Hours Min.	10/23/	1978 Forei	ountry) MD
	ŀ	Usual Residence of Decedent				Land to the City City City City
* any		10a. State 10b. County Prince George 10c. City, Town or Loc				10d. Inside City Limits 1 Yes 2 No
Aaryland 28a-f show 1 at once	ģ	110 11111 001900 2000	10f. Zip Code	100	Citizen of What Cou	
th the Maryland 23a or 28a-f sho	irec	9759 Mountain Laurel Way 2A	20723	109	US	1
215-0036 be filed within 72 hours after death with the Maryland mall Hygiers, etcled other than "natural", or items 23a or 28a-fish ent, the Medical Examiner must be notified at once	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp			rican Indian, Black,
leath v	nue	1 Never Married 2 Married Armed Forces?	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
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hours natur Exam			ent's Usual Occupation (Give kind of w most of working life. DO NOT use reti		6b. Kind of Business	
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Com	17. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Ma	iden Surname)	
11215-0036 Id be filed within 72 hou fental Hygiene. narked other than "nat event, the Medical Exa	Be	James R. Traynham, Jr.	Joan	Harris		
hou hou is n	٦	MUSDANI	ing Address (Street and Number or A Mountain Lourel W	Λ :		el, MD 20723
, MD and 2 sh ealth and em 27 is			osition (Name of cemetery,		20c. Location - City of	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and Mimportant: If item 27 is ninjury or other traumatic.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	other place)	07/08	Davinas	Mills, MD
Iltim nit. Pa artmer ortan		4 Donation 5 Other Specify: OWI 1507 21. Signature of Funeral Service Licensee	To rest 04 Name and Address of Facility Va	Mahn C. Gr	cene Fund	eral Services
De per I		(1) (1) (1) (1) (1) (1)	728 Libertu Road R	andalistov	un MD 211	33
hysician		23a. Part I. Ent ir the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	r the mode of dying, which as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ne and promethazine)	Intoxication	on	Death
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be executed ician and urial - trans	dical		ME g878 4/21/08 amh			
Box 68760, a death certificate be the attending physic ed for use as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pregr	nancy	23d. Date of delive Month	ery Day Year
x 68 h certi tendin	iciai	past 12 months? 4 Pregnant at time of death 5	Other (Specify)			
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cords, P law requires t has been sign 2 should be e	Completed by			24a. Was ar		autopsy findings available
COFC law re has be	edu			autops perform	ned? death	
Division of Vital Records, tal or Attending Physician: The law require re after death. al Director: After this certificate has been siled in by the fineral director, page 2 should be led in by the fineral director, page 2 should be	ខ	25. Was case referred to medical	26.Place of Death (Chec	1 Yes 2	No1 ✓	res 2 No
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ViSi or Att of ther do Direct in by	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.	or Town, Sta	^{ate} 9759 Mount	Rural Route Number, City ain Laurel Way
Division Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Sel	4 Homicide determined (Specify) Found at home		#2A, Laure	el,MD	
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To the within 2 To the complet	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (
		\ m/. 1/=	O.C.M.E.		March 30, 200	8
-/		30. Name and address of person why completed cause of death (Item 23a)				
Ø		Jack Titus MD. Deputy Chief Medical Examiner 111 F	Penn Street, Baltimore, MD 2	21201		
S Regis	tate	<u> </u>				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 11092

thony R. Hard		For State Of Maryland / Department of Fleath and Montal Hygies Certificate of Death	Reg. No		00 1103
Dhypioin	R		te of Death		3. Time of Death
Physicia Examii		Anthony Kay Harden Ma	rch 29, 200	18 4c. County of Death	1920 hrs
•	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Gwynn Oak	1	Baltimore Cou	
		925 St. Agries Laite	ate of Birth(MI	M/DD/YYYY) 9. Bir	thplace (State or
Funeral	5	S. Social Security Number 6. Sex 7. Age (III yis. lost Estates) Months Days Hours Min.	5/27/19		untry) MD
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5-0036 led within 72 Hygiene. t other than	ompl	12 Method's Name (Firs	st, Middle, Maid	ien Surname)	· · · · ·
21215-0036 ald be filed within 72 hours after death with the Maryland Mental Hygiene, marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Be C	17. Father's Name (First, Middle, Last) Henry F. Harden Eleanor		port	
F P P P P P P P P P P P P P P P P P P P	B	19a Informant's Name/Relationship (Type, Print) / 19b. Mailing Address (Street and Number or Rural			te, Zip Code) Apt C.
e, MD 1 and 2 sho Health and item 27 is		/ / / / / / / / / / / / / / / / / / /	MSVIII	Oc. Location - City	or Town, State
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Page:		4 Donation 5 Other Specify:			
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other t	- 10	$\mathcal{L}_{\mathcal{L}}}}}}}}}}$	70allst	WIN MD.	21133
ysician		23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dyins, su h as cardiac or res	piratory arrest,	shock, or heart	Approximate Interval Between Onset and
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sd sit	Examiner	events resulting in death) Last			
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SiOI Attender r death ector:	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28			r Rural Route Number, City
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Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Pinneral Director: After this certificate has been strong the former after the former after the control of the law in the former after new 2 should	<u>a</u>		ue to the cause	e(s) and manner as	stated. to the cause(s)
o the	Medical	Certifying Physician: To the best of my knowledge, death occurred at the line, date and place, and at (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the line, date and place, and at the line, date and place, and at the line, date and place, and at the line, date and place and the line and the li	ne lime, date d	29d. Date signed	(Month, Day, Year)
	´ Š	29b. Signature and title of certifier O.C.M.E.		March 30, 20	
		Potrice (Monica-Toller 10			
d		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	, MD 21201	I	
r	Stat	31. Date filed (Month, Day, Year) 7. Registrar's Signature			
	state istra				

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ORIGINAL

		•	For State Registrar		State	of Mar	yland	-	artmen rtificate			and M	lental Hy	giene Reg. No	7111	8	110	93
P	hysicia	ın	1. Decedent's Name (First, Margaret										Date of De Month	Da	, 2000	ear	3. Time of De	eath
	/Medic	al .	4a. Facility Name (If not ins			umber)			4b City	Town, or	r Location o	of Death	April	4	2008 County of		6:58a	IVI
) E	xamin	er	201 St. Mar						West			or Dodan			rrol1			
	neral ector		5. Social Security Number 220–30–8697		ex □м 2 / Д F	7. Age ((In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept. 25	th 1 <i>y, Year)</i> 5,19	34 l	Cour	olace (State or F ntry) 1and	Foreign
land	ow II		Usual Residence of Deced 10a. State 10b. C	County		1	Oc. City, T	Fown or Lo	cation							1	0d. Inside City	
Mary	a-t sh	cto	MD Ca:	rroll			West	minst	ter								1 □Yes 2	ÐN∘
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03 2008 1:15 PM APRIL EDWIN WILLIAM INGLIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Agnes hospital Baltimore, MD If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days 1⊠M 2□F Director 85 216-16-2414 Apr20, 1922 New York Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 2 should be filed within 72 hours after death with the Marylan and Mental Hyglene.

Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medica Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland | Baltimore County Catonsville 10g. Citizen of What Country? 10e. Street and Number 717 Maiden Choice Lane 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive Petroleum Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fill Health and Mental H John Albert Inglis 2 Beatrice Shattuck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any Injury or other trau 717 Maiden Choice Iane, Baltimore, Maryland 21228 of Disposition (Name of Date 20c. Location - City or Town, State Mrs. Ruth M. Inglis (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 4/5/2008 Baltimore, Maryland 21. Sign of of Fundal Se viol dansee awarn Martin D. Lawson 22 Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) IWK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar the death certificate be execu-Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day signed by the at d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier I avaid M MD P-19514 April, 03, 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore, mD, 21229 TARIL MAHMODD 900 Caton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Edwin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 165 A M Month Year **Physician** Agni Petronella Immler 2008 Helen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Manchester Longview Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 🗙 F 87 Sept.6,1920 Pennsylvania Director 218-03-1042 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mertal Hygiene.
Instit if item 27 is marked other than "natural", or items 23a or 28a-f show mist if item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notifiled at ury or other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 No Baltimore Highlands Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227 2909 Vermont Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Petronella Barbara Zemanskautis Frank Zydelis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 804 Clearview Avenue, Hampstead, MD 21074 Mr. C. Gregory Immler, Son Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Department of Most Holy Redemer Cemetery 04/07/2008 Baltimore, Maryland Important: if any injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley Ashton Funeral Home M01113 2134 Willow Spring, Dundalk, MD 21222 Mullion anuw Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroscierotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dile to fur as a consequence of: Examiner death certificate be executed attending physician and for use as the burial-trae Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death signed by the a d be detached f 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Ûnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Y Yes 2 No has 2 No certificate 1∏ Yes Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA မှ After this funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Certification: (Month, Day Year) To the Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

V

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dobarah I Picrcs 25 MAIN STRET

REISTERSTOWN MD

31. Date filed (Month, Day, Year)
APR 0 7 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:30AM 2008 April Paul Guthrie Jones, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 9421 Northgate Rd Laurel Birthplace (State or Foreign Country) 8. Date of Birth If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours 1**X** M 2□ F 5/28/1931 Massachusetts 76 028 22 3677 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 ☐Yes 2 XNo notifled Directo MD Howard Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with and Mental Hyglene. It's marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be remematic event, the Medical Examiner must be removed. 20723 United States 9421 Northgate Rd 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1XIYes 2 □ No If Yes, Give Year or Dates: 1954–57 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Co-Owner 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Suzanne Martin Paul Guthrie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9421 Northgate Rd Laurel, MD 20723 f Health a Betty Wilson Jones/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4-4-2008 Ardent Crematory Hanover, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Ollin -4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arrest Cardioresmin **Physician** /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, frame and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as conse uence of: Examine Pancy ta y burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the attending properties for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9 I Inknown 23e. Did tobacco use contribute to the cause of death? been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1□ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) 2₽ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

State Registrar (Month, Day, Year) 2008 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

& Mary land

20065

April 4, 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 11097

			I- For State	, , ,	Certif	ficate of	Death				eg. No.			
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			4a. Facility Name (if not institution Bon Secours Hospital		er)	[4]	Baltimore	Location of	Deau		10.00	WI	1	ł
			·		Age (In yrs. last	hirthday)	If Under 1 Ye	ar If Under	r 24Hrs.	8. Date of Bi	rth(MM/DD/	YYYY) 9.	Birthplace (State or	
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) 21215-0036 hould be filed within 72 hours after hould be filed within 72 hours after hour Mental Hygiene, is marked other than "natural", ttic event, the Medical Examiner	o Be	Johnathan 19a. Informant's Name/Relations	n Jacks	on	19h Mailing	Address (St	null has too	her or Ri	a R	ımber. City	or Town, S	State, Zip Code)	-
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	Baltimore, Moemit. Pages 1 and 2 Department of Health Important: If item 2 nijury or other traum		1 Burial 2 Crematio	n 3 Removal from	State	ematory or oth	her place)		Vi m	72110	c Cait	cnsvi	Ile, MD	
	_ = -		4 Donation 5 Other S	Specify:		22 N	Name and Addr	ess of Facilit	V.	1, 2002		-20	Sanara	_
	Balti permit. Departi Importi injury		21. Signature of Furieral Service	C. M.	-	[22	Roral	KRED	Gya	yson	ass.	BW	to mid 212	29
-	nysician		20a. Method of Disposition 1 Bunal 2 Crematio 4 Donation 5 Other S 21. Signature of Funeral Service 23a. Part I. Enter the disease, of failure, List only one cause.	r complications that cau	sed the death. I	Do not enter t	he mode of dyi	ng, such as c	cardiac or	respiratory a	arrest, shock	, or heart	Approximate Int	ervat
4	Medical		tallare, Elst erily erie ease.	Acobs	xiation								Death	
	Examiner		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a c	onsequence of)	:								
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		l a	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of)	:								1
	executed an and al - transil			d										
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	760, icate be grant physicial the buria		IF FEMALE: 23b. Was decedent pregnant in	the	itcome of pregn	ancy	etal death	3 Ectop	ic pregna	ncv	1	Date of de Nonth	Day Yea	r
	certification ce	cian	past 12 months?		nt at time of dea	who —	ther (Specify)		70 p. 03.10	,			·	
	Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 U	3 GIIKIIGT										h0
		1	Part II. Other significant cond	litions contributing to	death but not re	sulting in the	underlying cau	se given in P	Part I.				te to the cause of deat Probably 4 Unkn	
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	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the reached cleath. an Director: After this certificate has been signed by led in by the funeral director, page 2 should be deadled.	Ü	25. Was case referred to medic					lace of Death	n (Check	only one)				- 10
	Vit; hysici this c	To B	examiner? 1 ✓ Yes 2 No		patient 2			Other ₄		ng Home 5	Residen		Other:	
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	ion trendi leath. tor:	atio		inding vestigation FN 3/2	8/2008	Fnd 1:4	42 pm						or Rural Route Numbe	
	ivision or Attendante death Director:	Certification:	3 Suicide 6 Co		of Injury - At ho roadway	ome, farm, stre	eet, factory, offi	ce building, (etc.	or Tow	n. State)			10.0
	Spital hours neral	5	4 Homicide										n St. Baltimon	C _k . I)
	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I Completely filled in by the funeral director, page	g	(Check only 1 Certifying one) Medical Ex	Physician: To the best kaminer:On the basis of	of my knowledg f examination ar	ge, death occu nd/or investiga	urred at the tim ation, in my opi	e, date and p nion, death o	occurred	at the time, d	ate and place	e, and du	e to the cause(s)	
	To the within 2 To the complet	Medical	29b. Signature and title of certi	and manner sta	ated.			cense numbe					(Month, Day, Year)	
4		-	Design M	11			0	.C.M.E.			Marc	ch 29, 2	008	
			30. Name and address of pers	on who completed cause	e of death (Item	23a)								_
			Pamela E. Southall,		Aedical Exa		11 Penn St	reet, Balti	more, I	MD 21201				
		State	31. Date filed (Month, Day, Yea	ar) 32 Re	gistrar's Signatu	ire	. 20. 1			_				
	Regi		4 m m A P	7 2008	Carre All	1500	40				OCHE			
D	HMH 17 Rev 1	/2001		-		OŘIGIN	AL				OCME			

Registrar

State

WAN

31. Date filed (Month, Day, Year)

APR 0 3 2008

SUITE 4890

BALTIMORE

MD

21204

NORTH CHARLES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMILTON

6701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a,25,27,28a-f per me 8878,04/03/08dhb Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 19, 2008 KANE **Physician** CHARLES 7:40 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Catonsville Commons 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 10, 1917 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex **Funeral** Months Days Hours 1 X M 2 □ F Pennsylvania 213-03-8805 90 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 1 YYes 2 □ No **Baltimore** Maryland N/A Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or any liury or other traumatic event, the Medical Examiner must be a 21230 1033 Riverside Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW 2 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ρ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gordon Carton Printer 0 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kane Mary Fronnecht Charles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Clark Rd., Lot C-43 Jessup, Md. (Daughter) Linda Hanna altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Md. Veterans Cemetery 3/26/08 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Baltimore, Md. 21230 21. Signature of Funeral Service Licensee Kevin E Ecker Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): RIPPLE for THUS Examiner Sequentially list conditions, if any, leading to infunediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION A PROLED BY MEDICAL EXAMINER The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 UN To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 X Yes -2₽ P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month. Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Filvanual $\boldsymbol{p}_{\,\text{M}}$ 03/02/2008 1 Yes 2 No 2 Accident Unknown Probable fall within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 Fusting Ave. 4 Homicide Nursing Home Catonsville, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

MAR 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. TURAKHIA, MD. 1009, Frednige Rd. Caferynick, 31. Date filed (Month, Day, Year)

2008

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

D36942 March 19,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Margaret M. Kmetyk April 12:45 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Ruxton Baltimore Towson If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Jan 31, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 F Ireland 170 30 9503 89 1919 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural;" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 912 S. Rolling Road 21228 Ireland Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No White \$ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Murphy Bridget Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4918 Harrogate Road Ellicott City, MD 21043 Mary Ann Kmetyk/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 XRemoval from State St. James Church Cem. 4-9-2008 Sewickley, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DEMEN T /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the t JE FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I signed by the a 1 Yes 2 XNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy page perform certificate 1⊟ Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending 5 ☐ Pending investigation 1 Natural (Month, Day Year) within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and in 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

1838

31. Date filed (Month

GREENE

D57722

PIKESVILLE MD 21208

LEONARD

April 6, 2008

RICH ARDSON M.D.

M.D.

ROAD #300

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TREE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** NAOMT KELLER 10:45P M 2008 April 01. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Lambourne Road, Unit 103 Baltimore Towson 8. Date of Birth (Month, Day, Year)
Jan. 19,1917 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 □ vF 213-10-5033 91 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes Ž**X**No Director MD Baltimore Towson 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21204 USA Unit 103 Lambourne Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No f Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) 6 Meat Packer Food Service traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Larkin Hamilton Birmingham Vera Elsie Wayson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trains Rose Cray (Daughter) 31 Lambourne Road, Unit 103 Towson, MD 21204 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ment of F 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 4/5 4 □ Donation 5 □ Other (Specify) Elkridge, MD Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd. Elkridge, MD 21. Signature of Funeral Service Licenses MOI pucations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Inter the disease or heart failure. List only Immediate Cause (Final disease or condition resulting in death) vater **Physician** /Medical Due to (or as a uence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo (or selections agreence of) law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No cate has been si page 2 should i 1 ☐ Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After t 28c. Injury at Work? or Attending 5 Pending investigation atural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

DHMH 17 Rev 1/2001

29b. Signaty

ed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

Farmont Ave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIPM/25 per PHYS. 08/8.4/7/08/WS
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** PM **EDITH** KARCH 20 56 APRIL 01 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sallemore sultimore Hospital Jennie Citi N/A Year If Under 24 Hrs. 8/ Date of Birth (Month, Day, Year) 07/27/1925 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Min Months Hours Country 1 M 2 X F Yrs. 213-20-3241 GERMANY Director 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural;" or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at any Injury or other traumatte event, the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6414 PARK HEIGHTS AVENUE, #D-1 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: WHITE þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ALBERT RING BELLA ROSENBUSCH ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3108 HUNTMASTER WAY, OWINGS MILLS, MD ANNETTE SNYDER / DAUGHTER 20b. Place of Disposition (Name of central repairs) (Name of Carter place)
ANSHE CHAIM CONG. 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of I 1 Burial 2 □ Cremation 3 Removal from State 4 Donation 5 DOther (Specify) 04/03/2008 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 day Intraparentymul remin /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria OVED BY MEDICAL EXECUTIVES Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown tate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 ☐ Yes 217 No 3 ☐ Probably 4 ☐ Unknown Julullut Completed Was an autopsy performed?

Ves 212 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ontu vumiy Courtin 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -27 No 1 patient ို 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1100 AM 1 ☐ Yes 2 No MARCH 31 2008 2 Accident Standy ull mon 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locatio (Street and Number or Rur Ro te Number, City or Town, State) 4 🔲 Homicide AT HOME PARIL 6414 HTS AVE BALTIMURE 40 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 21215 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ١0 Bureack 19 ve #16 21215 WEINTM B 431) West 32 Registrar's Signature 31. Date filed (Month) Year) State Registrar

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Marie Anita LePore

4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F Dominican Republic 219-16-3440 84 03-08-1924 **Director** Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21214 6500 Eastern Parkway U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 No Specify: ģ Specify: White 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Athletic Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Bauer Anita Madsen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ant: If item 27 is ury or other trains Mrs. Marie Balderson - Daughter 2848 Rolling Fork Way Glenwood, Maryland 21738 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or Parkwood Cemetery 04/08/2008 Parkville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Charles 1 Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AORTIC STENOSIS Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner use as the burial-trans Due to (or as a consequence of): attending physician for use as the burial IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 AT2438946 30. Name and activess of person who completed cause of death (Item 23a) (Type, Print) D MEMORIAL HOSPITAL UNION 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 7 2008 DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. C.

Day

Year

2008

Time of Death

7:53 PM

2. Date of Death

Month

APRIL

	•	For State Registrar		Olalo o	· maryiar			of Health and of Death	····oritar i		g. No.	2008	3 11104	
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	To	19a. Informant's Name/Relations			<u>:e</u>	19b. Ma	ailing Address (S	Street and Number or F				1tmars		
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29b. Signature and title of certifier

Joel A. Guiterman,
31. Date filed (Month, Day, Year)
APR 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

D. 2141 K Street,

29c. License number

DC16518

N.W., Suite 603 Washington, D.C. 20037

29d. Date signed (Month, Day, Year)

April 5, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02208 State of Maryland / Department of Health and Mental Hygiene Melanie Muhammad Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 19, 2008 1838 hrs Medical Examiner Melanie Muhammad 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Sinai Hospital 9. Birthplace (State or unk If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) 5. Social Security Numberink 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Oct 30, 1993 Director Country) 14 2 X F M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No is 23a or 28a-f show e notified at once. Baltimore 28a-f shov MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 3616 Reisterstown Road 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married Married 2 X No Yes If Yes, Give Year Yes 2X No specify: Specify: white Divorced 3 Widowed <u>\$</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 unk none unk 18.Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in æta⁄te 2. Name and Address of Facilit 21 Signature of Funeral Se Board 655 W. Baltimore Street State Anatomy Baltimore, MĎ 21201 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death Pneumonia complicating Connective Tissue Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed physician and the burial - trans AMENDED 23a,27 per ME g8/8 4/8/08 amh sician/Medical X UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death ned by the attending detached for use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 ✔ Unknown Unknown Ph signed by the 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an After this certificate has been prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient Nursing Home 5 Residence 6 Other: 2 ER/Outpatient 3 DOA ٩ 1 🗸 Yes No 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registra

DHMH 17 Rev 1/2001

OCME 2006

State

Valu

32 Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 21, 2008

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

29b. Signature and title of certifier

Carol Allan, MD 31. Date filed (Month Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Mento Mary Concetta 2008 9:30 April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner <u>Baltimore</u> Rosedale If Under 1 Year If Under 24 Hrs. 1505 Neighbors Avenue 8. Date of Birth (Month, Day, NOV 13, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1923 Hours Months Days MaryTand 1 ☐ M 2 💢 F 84 215-12-3933 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 🙀 No Rosedale MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 USA 1505 Neighbors Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 X Widowed 4 □ Divorced Pages 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", ury or other traumatic event, the Medical Exa Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Koppers Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marsiglia Concetta Glorioso John ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1505 Neighbors Ave., Baltimore, MD 21237 Joseph H. Mento, III-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/7/08 Parkville, MD 4□Donation 5 □XOther (Specify) Entombment Parkwood Cemetery Baltimore Ma 5305 William G. Dau 22. Name and Address of Facility 21. Signature of Fundal Service License Maryland 212 305 Harford Rd Inc. Leonard J. Ruck 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease **Physician** 10 Cronavu resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a consequence of) Examine rsician and the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 🗌 Fetal death Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death certificate has been signed by the rector, page 2 should be detached 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 035069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Savora Wall 570N, M.D. 3100 WYMAN PRK DR.

Registrar DHMH 17 Rev 1/2001

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State

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31. Date filed (Month, Day, Year)

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HAIRSTON

2008

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 02/2008 John J. Miller, Sr. 08:14 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 7, 1918 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 215-05-2194 1 X M 2 □ F 89 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3230 E. Northern Parkway 21214 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Tyes 2 No WIII If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify to 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Modern Linotypers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Miller Catherine Gunther 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Miller/Wife 3230 E. Northern Parkway Baltimore Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 4/5/08 Baltimore Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harrord Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Acuto

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, #

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

Examiner

þ

Completed

Be P

Certification:

Medical

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medi-al Examiner must be notified at

within 72 hours after death

Baltimore, Maryland 21215-0036

certificate be exec Division or Vital Records, P.O. Box 68760, Physician/Medical

Sequentially list conditions,	b	
if any, leading to immediate cause. Enter Ungerlying	Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last	C Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
25. Was case referred to medical		th (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not I determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a Certifier 1 CertifyIng P	hysician: To the best of my knowledge, death occurred at the time, date and place	and due to the cause(s) and manner as stated

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN H. KANN, NO 7602 31. Date filed (Month, Day, Year) APR 0 7 2008

29b. Signature and title of certifier

2. Registrar's Signature

D28662

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Bel air Road Bultimore Md 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nd Items 23a.25.27.28a f Department of Health and Mental Hygiene

		-	For Amend Items State Registrar	230,23,21	,20a-1	Čert	ificate of I	Death	KIIID	Reg. No.	UUC	3 11103
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	Physicia /Medic		Donald E.	Morse					March	_		12:51 P M
	Examin		4a. Facility Name (If not institution, give	e street and number)			•	Location of Death	1		ounty of Dea	
~£	Ģ.	9-	20005 Mattingly To		(in yrs. last	hirthday	Gaithers	burg	8. Date of B		ntgome	thplace (State or Foreign
150	Funeral Director		262-72-9310	X M 2□F	64	Yrs.	Months Days	Hours Min.	Feb. 8	ay, Year)	Co	buntry) Lifornia
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	r 28a	Directo	10e. Street and Number	LLY	Garen	CIDDO	10f. Zip Code			10g. Citize	n of What Co	ountry?
	th with		20005 Mattingly T	errace			20879			Unite	d Stat	es
	ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	pecify Yes or N to Rican, etc.)	0- 14	I. Race - Ame Black, Whi	
5-0036	be filed within 72 hours after death with the Maryland Hyglene. d other than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	1 [X] Yes 2 ☐ N If Yes, Give Year or Dates:	lo	1	□Yes 2🌠 No	Specify:		s	Specify: W	hite
ر ک	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	1	6a. Decede (Give k	ent's Usual Occup ind of work done of O NOT use retired	ation during most of wor	rking	16b. Kind	of Business	/Industry
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Z	iled v Hygie ther t		17. Father's Name (First, Middle, Last)	5+		Progi	cam Direc	18. Mother's Nan	ne (First, Middl			Contractor
ä	d be f	Be c	Donald Morse				1	Mary	DeMong			
Maryland	should that the should the should the short warked umarked	2	19a. Informant's Name/Relationship (Type. Print)	1	19b. Mailing	Address (Street			ber, City or T	Town, State,	Zip Code)
	nd 2 salth ar 27 is r trau		Sydney W. Morse	/ Wife	2	20005	Mattingl	y Terr.,	, Gaith	ersbur	g, MD	20879
ē,	ages 1 and 2 should be ent of Health and Mental t: If item 27 is marked of y or other traumatic eve		20a. Method of Disposition		20b. Place	e of Dispos	ition (Name of atory or other place	e) Mor	ch 12,	20c. Loca	ation - City or	r Town, State
altimore,	G E E E		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)		gomer	y Cremato	rium 2	008	Betl	nesda,	Maryland
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1	Physician		Immediate Cause (Final disease or condition	a. Colorect	tal Ca	ncer		1	4		add5	Months
i a	/Medical Examiner		resulting in death)	Due to (or as			. /	1//	1/2/	LIPPULA	MIII	Months
	* A=	er	Sequentially list conditions, if any, leading to immediate	b. Cardiac	Dystin	os oth.	a /	1//	CAL E	XAMINER		Honeno
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Ř	eath cer attendir for use	Physician/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3 🗌	Ectopic pregnancy Other (specify)	/			Month	Day Year
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ecords, P	law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditions of	contributing to death b	ut not resultir	ng in the un	derlying cause giv	en in Part I.			e contribute No 3 □ F	to the cause of death? Probably 4 🛣 Unknown
Ö	v requ	etec							24a. Wa	ıs an	24b. Were a	autopsy findings available
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o 	nysic nis ce direc	To E	examiner? 1 X Yes 2 X No	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER	VOutpatien	t 3□ DOA Oth	er: 4 🗆 Nursing F	Home 5 NR Re	sidence 6	□Other (Sp	ecify)
0	ng Pt fter tt ineral		27. Manner of Death TXNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Bb. Time of Injury	28c. Inju	y at k?	28d. Describ			
Sio	tendl eath. tor: A the fu	cati	2 X Accident investigation 3 ☐ Suicide 6 ☐ Could not b			nknow		Yes 2 XNo	Multip			Pural Pouto Number
Division	or At titer d Direct in by	Certification:	4 Homicide determined		c. (Specify)	e, iaim, sire	eet, factory, office		City or 7	own, State)	20005	Mattingly
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is		29a. Certifier 1 X Certifying Pl	vsician: To the best	of my knowle	edge, death	occurred at the ti	me, date and plac	e, and due to the	ne cause(s) a	and manner	urg, MD as stated.
	ne Ho n 24 h ne Fui	Medical	(Check only 2 Medical Examone)	miner: On the basis o and manner sta		n and/or inv	estigation, in my	opinion, death occ	curred at the tim	e, date and	place, and di	ue to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Mor	nth, Day, Year)
}				Have	W)		D357	92		March	n 10,	2008
			30. Name and address of person wh					U=0:	1) (T) (0000	
			Swaroop G. Rao, M. 31. Date filed (Month, Day, Year)		Edmon ar's Signatur		Drive,	#504, Ro	ckville	, MD 2	20052	
		ate	or. Date med [Worth, Day, Teat)	I BE TREGISTI	ar o organiqual	- #						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL 3^{Pay} 20ď8 **Physician** MAZYCK 3:43 Рм MOORE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2 F 67 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 Yes 2 No FREDERICK MA. FREDERICK "natural", or items 23a or 28a-f shedical Examiner must be notified by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RUTCEDGE PLACE TO 2/703 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1□Yes 2⊅No Baltimore, Maryland 21215-0036 Specify Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOUSEWIFE or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOGWEN Is marked KNOX RICHARD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK MO 21703 Department of Health a Important: If item 27 Is any injury or other tra T-C RUTCEDEE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State pril 12,2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fability GARY L. ROLLINS FUN ITOMIC gary 2. /Colles SOVAL ST FREDERICA MO 21701 WEST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her in failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Interction Physician Myocardial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Anoxic attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an cate has b autopsy 2 No certificate To the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

State Registrar

28. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Spnature

D0064624

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mason Griffin Medicus State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner 1540 hrs Mason Griffin Medicus April 1, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Saint Joseph's Hospital Towson **Baltimore County** 5. Social Security Number 6. Sex If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year oreign Director Min 214 81 1104 1 X M Country) 02/02/2008 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. Yes 2 X No MD Baltimore Glen Arm hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11760 Glen Arm Road 21057 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White etc. 2X No Yes Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: White "natural". ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 I tent of Health and Mental Hygiene. None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Frank L. Medicus III Stephanie Greenhalgh Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is n ther traumatic Frank L. Medicus III/Father 11760 Glen Arm Road Glen Arm, MD 21057 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, or other crematory or other place) 1 X Burial 2 Cremation 3 Removal from State partment o Dulaney Valley Cem. 04-05-2008 Timonium, MD 4 Donation 5 Other Specify 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Between Onset and /Medical Death Sudden unexplained death in infancy Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED the attending physician ed for use as the burial -#MENDED, 28a-f perME, g879 5/23/08 TT Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Yes 2 ✔ No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No No 1 🗸 Yes 25. Was case referred to medical or Attending Physician: 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other 4 Inpatient 2 V FR/Outpatient 3 DOA Nursing Home 5 Residence 6 After this ٩ 1 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural hours after death. Yes 2 X No Pending Fnd 4/1/2008 FNd 2:36 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) 11<u>760 Glen Arm Rd. Glen Arm, MD</u> the Hospital determined (Specify) the Funeral Homicide found at home 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 0 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jam M O.C.M.E. April 2, 2008 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registra DHMH 17 Rev 1/2001

OCME 2006

State

OCME

32. Registrar's Signature

31. Date filed (Month, Day, Year)

APR

08-02464	4
David A.	McGowan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Crivial yiarid / Department Ce.	rtificate of Death		g. No.	b IIII			
Physicia Medical Exami		Decedent's Name (First, Middle,Last)		2. Date of Deat	h Dav Year	3. Time of Death			
ii. Maar Exami		David A. McGo 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	March 29,	4c. County of Death				
		4800 Chevy Chase Drive #505	Chevy Chase		Montgomery				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I	Months Days Hours	Min	h(MM/DD/YYYY) 9. Birt Foreig	n			
		578-44-8617 1X M 2 F 73	Yrs.	Februar	y 17,1935 Was	hington,D.C.			
' any			, Town or Location		10d. Inside City Limits				
·land ·f show	tor	Maryland Montgomery	Chevy C						
ie Maryland or 28a-f show <u>fied at once.</u>	Director	10e. Street and Number	10f. Zip Code		g. Citizen of What Cour	itry?			
with th		4800 Chevy Chase Drive #50 11. Marital Status 12. Was Decedent Ever in U			United 14. Race - Ameri				
death must h	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	White, etc.	,			
s after rall", o	by	3 Widowed 4 Divorced If Yes, Give Year 1950 * 15. Decedent's Education (Specify only highest grade completed)			Specify:	White			
72 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give I during most of working life. DO NOT		16b. Kind of Business/li	ndustry			
vithin ene.	ldw	12	Sales		Retail				
21215-0036 Ald be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last)	18.Mother	s Name (First, Middle, M	,				
212 Suld be Menta mark ic even	To B	Aloysius McGowan 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Num	Mary ber or Rural Route Num	y 0 Connor ber, City or Town, State	Zip Code)			
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatite event, the Medical Examiner must be notified at once.		Edwin Van Meter/ Cousin	512 Thomas Street	, Stroudsbu	rg, Pennsylv	vania 18360			
Baltimore, permit. Pages I ar Department of Hes Important: If itel		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date April	20c. Location - City or	Town, State			
Itim it. Pag irtment ortant;		4 Donation 5 Other Specify: 21. Signature of Fyreral Service Licensee	rematorium Inc.	4. 2008	Bethesda,	Maryland			
Ba perm Depa Impe		Want MOO!	22. Name and Address of Facility Bethesda-Chevy (Bethesda, Maryla	Thase Inc. 755	Wiscosin Av	renue			
Physician		23a. Part I. Enter the disease, or communications that caused the death failure. List only one care in each line.	. Do not enter the mode of dying, such as ca	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and			
/Medical .xaminer		Immediate Cause (Final disease a. Cocaine use com 1	icating hypertensive ath	erosclerotic c	ardiovascular	diseaSe th			
		or condition resulting in death) Due to (or as a consequence of Sequentially list conditions,	т):						
	iner	if any, leading to immediate Due to (or as a consequence o cause. Enter Underlying Cause	f):						
is a col	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of the	f):						
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760, icate be ex. physician the burial	Medical	IF FEMALE: 23c. If yes, outcome of preg			23d. Date of delivery				
x 687 h certific tending p use as th	sician/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of de	2 Fetal death 3 Ectopic	pregnancy	,	ay Year			
Box 68' e death certiff the attending ed for use as	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)						
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IS, P.C quires that en signed uld be deta		·	<u> </u>	_	2 No 3 Prob				
cords law requi	Completed			24a. Was a autops	sy prior to c	opsy findings available ompletion of cause of			
tal Recian: The certificate		25. Was case referred to medical	26.Place of Death (1 ✔ Yes 2		s 2 No			
of Vital Records, ng Physician: The law require ther this certificate has been sineral director, page 2 should be	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other;		Residence 6 V Other	: Scene			
n of ling Ph After t	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work	ı	ow injury occurred				
Division tall or Attendiners after death.	läi äi	2 Accident Investigation	No Sof Leasting (0						
Division Hospital or Attene 24 hours after death Funeral Directors rely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, St	treet and Number or Ru ate)	al Route Number, City				
Hosp 24 hor Fune etely fi		29a. Certifier 1 Certifying Physician: To the best of my knowled							
Di To the Hospital within 24 hours a To the Funeral I	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated.		curred at the time, date a					
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) March 29, 2008				
0000	1	30. Name and address of person who completed cause of death (Item							
2 bar.	-1	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
Sta	ite	31. Date filed (Month, Day Year) 008 2. Registrar's Signatu	ire hadis						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 8:35 Anita Floyd Mitchell April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase
If Under 1 Year If Under 24 Hrs.
Months Dave House Min Brighton Gardens Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1 ☐ M 2 🗓 F 579-09-3462 Yrs May 31, 1917 Director 90 Washington, D.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 □Yes 2 X No Examiner must be notified Directo Maryland Prince George's Silver Spring 10e. Street and Number 10g. Citizen of What Country? 'natural', or Items 23a or 3158 Gracefield Road #FC118 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I is marked Henry Floyd Lena Ruppert ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum 3158 Gracefield Rd. #FC118, Silver Spring, MD 20904 Robert C. Mitchell/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State April 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Foneral Service Licensee M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End Stage Alzheimer's Dementia year /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia 3 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): P.O. Box 68760, nding physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed' 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Așșișted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 反Other (Specify) 1 ☐ Yes 2 ☑ No 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day 5 Pending investigation s after death.
ral Director: Aff 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a To the Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061382

Registrar DHMH 17 Rev 1/2001 14816 Physicians Lane #152, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Shama R. Mittal, M.D.

April 2, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND TITEM 20th per FH C878 4/7/08 IS State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 468 M **Physician** SARAH MARKS APRIL 2008 /Medical Am 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NORTHWEST HOSDITHL CONTER If Under 1 Year If Under 24 Hrs. BALTINEANE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth **Funeral** 1 □ M 2 1 F Months Days Hours 08/27/1913 212-26-1665 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1525 N. ROLLING ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BERNARD BLINSTEIN PAKHOIS FANNIE ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5006 HOLLINGTON DRIVE, #205, OWINGS MILLS, MD f Health MARCIA ROSEN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
BNAI ISRAEL CONG. 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Iter
any Injury or ott
once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/06/2008 BALTIMORE, MD 4☐Bonation 5☐Other (Specify) 22. Name and Address of Facility Signature of Juneral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESWILL MD 21208 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that callsed the shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Andioney OpA Tetay /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) CENTIFICATION APPROVED BY MEDICAL EXAMINER that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CENCET I. WE HEART FALLENCE PLECURAL EFFLISCES CHARACTERS.

CHARACTERS CONTROL OF THE PROPERTY OF THE 23e. Did tobacco use contribute to the cause of death? <u>ک</u> POSTELAR TOVE SULANDINATE DISTRICE; PALIZOXYUNGE ATRIBLE
FIBRILLATION; STATUS POST AUCTOMATIC INDIANTABLE CANDIOVERTED WAS AN AUCTORY
DEVICE; AND ODDIENE TOXICITY OF LINE WAS WARRY TOXICE AUCTORY 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No AND BUTTOCK HEAD LACENATION LOS ECO TUSION BOTH HOPE SECONDARY TO FALL 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 wes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 2 Accident 3-28-2008 inknown subject 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 2122X 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1525 N. Rolling Rd. Cutonsylle MD (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AiriL 2, 2008 1) 19582 NENTHOUST HOSPITAL CONTEN 30. Name and address of person who end ed cause of death (Item 23a) (Type, Print) ORLHNDO CONANAN IND 31. Date filed (Month, Day, Year) 2. Registrar's Signature 7 2008 Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 4, **Physician** 2008 4:00 A M Evaline K. Norton /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Edenwald Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 4/12/1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F West'y Virginia 235-30-0165 84 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Towson Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 18 Wilfred Court USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assesments Supervisor State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie B. Conrad Ernest C. Kimble ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Wilfred Court Towson, Maryland 21204 Edith Nickerson/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/8/2008 Dulaney Valley Mem. Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland 21204 Towson, 1050 York Road Ruck Towson Funeral Homé, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) w /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, signed by Division of Vital Records. Completed by cate has I Be Medical Certification: To

s after death.

I Director: After to in by the funeral within 24 hours aft

To the Funeral Di

completely filled in

	24a. Was an autopsy findings available autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No)									
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
27. Masper of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? M 1 Yes 2 No										
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) Certifying Phyone) Medical Exam	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										

UI

State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

29c. License number

29d. Date signed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death?

2 No

1 🗌 Yes

Ye ar

3 Probably 4 Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAV Nov 10 em

31. Date filed (Month, Day, Year) APR 07 2008

29b. Signature and title of certific

32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

2008

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AMNUTITEM Co. per PHYS. (878 4/7/18 US)
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL **Physician** 2008 9:05P M ROSSMAN MARK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 3942 BRYONY ROAD RANDALLSTOWN Birthplace (State or Foreign Country)
 GERMANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 03/12/1912 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 96 046-24-9596 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director RANDALLSTOWN MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō USA 23a 3942 BRYONY ROAD 21133 Funeral or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: þ Specify 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene... Important: If item 27 is marked other than any injury or other traumatic event, the Man any olines. Elementary/Secondary (0-12) College (1-4or 5+) TAILOR GARMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PRESANT ္ပ SHMUEL ROSSMAN CHANA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3942 BRYONY ROAD, RANDALLSTOWN, MD SUSI ROSSMAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 04/04/2008 RANDALLSTOWN, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Fineral Service SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septicemia **Physician** disease or condition resulting in death) /Medical Examiner Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Gerelmorriscular Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy perform 2 A No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D23679 04-03-2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Suit 200 Kenneth L. Glick mo 10755 Falls 21093 31. Date filed (Month, Day, Year) APR 0 7 2008 2. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Robert E. Simpson 25, 2008 8:00 AM /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Asst Living Frederick Frederick Frederick 5. Social Securify Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1 ₹ M 2 □ F Director 461-16-0086 87 Jan 9, 1921 Colorado Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show or items 23a or 28a-f st eminer must be notified 1 ☐ Yes 2 ☑ No **Funeral Director** MD Frederick Frederick the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hyglene. 990 Waterford Drive 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: '43-47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No by Specify: Specify: White 3 Widowed 4 □ Divorced "natura!" Completed Item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ scientist radiological 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ Ralph Edmond Simpson Anna Hunderman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau Sarah Jean Pierson/daughter 304 Buttry Road Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Emperal Sen Ronal Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate dause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No the 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by pe certificate has been si rector, page 2 should I 1 ☐ Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed? Yes ME No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Living 1 Tes Other: 4 Nursing Home 5 Residence ٥ 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA After this 6 Other (Specify) SIN Rise 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

APR 0 7 2008

PEDERICK, Md 21701

of death (Item 23a) (Type, Frint)

0/1

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 25,30 per dr., g878, 04/07/08dhb Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Month Day Year Warner Franklin Stortz 12:50 M /Medical 30,2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Good Samaritan Hospital Baltimore City Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, August 17 9. Birthplace (State or Foreign Months Days Hours 1□M 2□F 213 16 4854 Director 87 Baltimore, Maryland 1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified Director Maryland Baltimore 1 ☐ Yes 2 ☐ No Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? p e 4500 H Talcott Terrace ms 23a 21128 USA Funeral ral", or items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Electronics Researcher</u> Westinahouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin S Stortz Annessie W Warner ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Stortz (wife) 4500 H Talcott Terrace Perry Hall, Maryland 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. April 1, 2008 Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home Inc 21. Structure of Funeral Service Licenses 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Unknown has been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 The certificate 1∐ Yes 2 No Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 2 No 1 ☐ Yes ER/Outpatient 3□ DOA 2 1 Inpatient After this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 ☐ Pending investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide in by t 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Rhosrow Tabassi,
31. Date filed (Month, Day, Year)
APR 0 7 2008

30. Nam

Good Samaritan Hospital, 5601 Loch Raven Boulevard, Balto., MD

32. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** SOMMERVILLE THOMAS 4PRIC 01 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMONE REHABILITATION EXTENDED CAPE GALTIMORE Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min 1 → M 2 □ F 216-42-7110 June 27,1943 West Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shoredical Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Co. Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 United States 5810 Farmview Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 2 Year or Dates: Vietnam 3 XWidowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printing Company Mechanic 12 Years permit. Pages 1 and 2 should be filed we Department of Health and Mental Hygis Important: If Item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Kelly Harold Sommerville 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1222 48th Street Baltimore, Maryland (Daughter) Patrice Seudalis Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 4/4/2008 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. alter 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LYMPHOMA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and Box 68760, ← Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CARDIOMYO PATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed' certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

P.O. Division or Vital Records, Hospital or Attending I 24 hours after death Funeral Director:

within 2

State Registrar 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

muer

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOULEVARD BALTIMORE, MD. THOMAS S. MILLETL 3900 LOCH RAVEN 31. Date filed (Month, Day, Year)

32. Registrar's Signature APR 0 7 2008

08-02595 Dawn Renee Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dawn Renee Smith		State of Maryland / Department of Health and Mental H	lygiene		
	R	- For State Certificate of Death		g. No. 200	8 1112
Physician		1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Medical Examine		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	April 2, 200	4c. County of Death	
\	•	University Hospital Baltimore	u.	To. County or Boom	
Funeral	ŧ	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	rs. 8. Date of Birt		hplace (State or
Director		220-74-0375 1 M 2 F 49 Yrs. Months Days Hours Mi	n. 13/09	1959 Foreig	untry) (1)
	F	Usual Residence of Decedent	00101	11,01	1000
any	[10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
show show	5	MD Baltimore			1 Yes 2 No
Maryla 28a-f 1 at o	3 7	10e. Street and Number	10	g. Citizen of What Cour	itry?
r death with the Maryland or items 23a or 28a-f show must be notified at once.	5	1033 New Hope Circle 21202		USM	
the with the n	<u> </u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (14. Was Decedent of Hispanic Origin? (15. Was Decedent of Hispanic Origin? (16. Was Decedent of Hispanic Origin? (17. Was Decedent of Hispanic Origin? (18. Was		14. Race - Ameri White, etc.	can Indian, Black,
	5	1 Yes 2 No		Specify: R	ack
ural" by	5⊦	3 Widowed 4 Divorced If Yes, Give Year 1 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind o	f work done	16b. Kind of Business/I	ndustry
5-0036 led within 72 hour tygiene. other than "natu the Medicial Exar	[]	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use re House keeping		\wedge	1
136 Thin 7 Than Tedica		ath Domestic	Priva	te	
5-0036 Hygiene. other than	3 7		ne (First, Middle, N	Maiden Surname)	
121 be fill be fill briked vent,		Gilbert W. Jackson Hele		Sample	<u> </u>
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Intent: Intent 71 is marked other than "matural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director	2 1	19a. Informant's Name/Relationship (Type, Print) ASNIEUT BOWENS (Day GHER) 3109 Ban Croft Ro	r Rural Route Num	ber, City or Town, State	Zip Code)
, Mand 2, and 2, earth 8	نا	HShley Bowens () aughter) 3107 Ban Crottkd 20a. Method of Disposition (Name of cemetery,	Date Date	20c. Location - City or	Town, State
Baltimore, M pernit. Pages 1 and 2 Department of Health Important: If tien 2 injury or other traun		1 Burial 2 Cremation 3 Removal from State crematory or other place)			
Baltimo permit. Page Department o Department important:	-	4 Donation 5 Other Specify: 1 1 22. Not e and Address of Fecility 22. Not e and Address of Fecility 2.	. 8.08	Baltino	re, mi
Balt permit. Departi Importinjury	ľ	Many City	Nat'I	uneral 50	an cos
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval
/Medical	1	failure. List only one cause on each line.			Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Alc. bol and Cycaine Introvication Due to (or as a consequence of):			
	_ ;	Sequentially list conditions, b			
		if any, leading to immediate Due to (or as a consequence of):	i re 🔫 "		
led nsit	֓֞֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֓֓֡֓֡֓֡	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ecuted and transit	$\frac{1}{2}$	d.			
.0, e be execut ysician and burial - tra	iL.	X UNPENDED AMENDED 23a, 27, 28a-f per ME g878 4/16/08 amh			
876 ifficate		F FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic preg	nancy	23d. Date of delivery Month	v Day Year
n of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phytuneral director, page 2 should be detached for use as the Art. To Be Completed by Physician/M	2	past 12 months? Pregnant at time of death 5 Other (Specify)	•		
Bo le dea the a	ÈL	1 Yes 2 No 9 V Unknown 9 Unknown			
P.O.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
S, F. Puires an sign and be			24a. Was a	AND THE RESERVE TO TH	topsy findings available
Records, The law require ficate has been si, page 2 should b. Completed			autop	sy prior to d	completion of cause of
Rec The I			1 Yes		s 2 No
cian:	b 2	25. Was case referred to medical examiner? Hospital: 1 Innation: 2 EB/Outcatient 3 DOA Other; Nurs			
Physical direction	2	1 V Yes 2 No Tospital Inpatient 2 ER/Outpatient 3 DOA Sure 4 Nurs		Residence 6 Other	
n of ding Ph	<u> </u>	1 Natural 5 D W (Month, Day, Year)		low injury occurred	
Division o spital or Attending hours after death. neral Director: After the control of the cont	3	2 Accident Investigation 4/2/05 UNK	Unk 28f Location (S	Street and Number or Ru	ral Route Number, City
Divi		Suicide 6 (Specific) Found on Street	or Town, S	tate) altimore St.Ba	
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Inversal Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans ledical Certification: To Be Completed by Physician/Medical Edical Estates.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, all	nd due to the caus	e(s) and manner as stat	ed.
To the How within 24 h. To the Fm completely ledical		Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	and place, and due to th	e cause(s)
To the within To the comp	2	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		O.C.M.E.		April 2, 2008	
4	3	30. Name and address of person who completed cause of death (Item 23a)			
0		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
State Registra	e 3	31. Date filed (Month, Day Year) 32 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Items 27,28a-f per me, 8/8/9/03/08dhb

Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Henry Scott March 3:43 AM Lee 14 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 1 □**Z**M 2 □ F Months Hours Director 86 247-28-2952 06 18 SC Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director MD NA Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 3407 Paton Ave 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filled within ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me 12th grade College (1-4or 5+) Grommer Horse Racing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Mae Rodgers Wilhelmina Mae Rodgers John Wesley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frizzella Scott-Wife 3407 Paton Ave, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or Garrison Forest 3/18/08 Owings Mills, Md 21. Signature of Funeral Service Licer March F/H West 4300 Wabash Ave, Baltimore, Md frome 21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Subdural **Physician** Henator disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner -211 CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, Examiner to (or as a consequence of) If any, loading to immedite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4⊡Pregnant at time of death 5 ☐ Other (specify) o detached 9□Unknown 9 Unknown signed by مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by coronary artery disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 7.2cm POLYCYSTIC Kidneydisease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No acrtic 24a. Was an out hyperlipidemia
Was case referred to medical examiner? autopsy performed? /es 2 No Division or Vital 1∐ Yes or Attending Physician: 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 ☐ Natural 5 ☐ Pending investigation 3:36 03/10/2008 s after death. 2 Accident \mathbf{p}^{M} 1 Yes 2 No Subject tripped and fell Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3407 Paton Avenue filled in by 4 Homicide Home To the Hospital or ithin 24 hours at the Funeral E Raltimore, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062770 March, 14, 200 8 + 30. Name and a id ess of person who completed cause of death (Item 23a) (Type, Print) Zeena Dorai Sinai HOS Pital

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 3 2008

Henry

Scott,

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mary C. Simmons		State of Maryland / Department of Health and Ment For State Certificate of Death egistrar		eg. No. 2 1			
Physician Medical Examine	/ 1	Decedent's Name (First, Middle,Last) Mary C. Simmons	2. Date of Deat Month April 2, 20	h Dav Year	3. Time of Death 2330 hrs		
	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location o Northwest Hospital Randallstown		4c. County of Dea Baltimore Co			
Funeral Director	3	Social Security Number 39-18-3015 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 39 Hours 7. Age (In yrs. last birthday) Months Days Hours	8. Date of Bird Min. June 2	th(MM/DD/YYYY) 9. B 1 1917 Fore			
ne Maryland or 28a-f show any fied at once.	1	State 10b. County 10c. City, Town or Location Sykesville 10b. County 10c. City		1			
the Marylan ia or 28a-f sl tiffed at one	1	0e. Street and Number 7200 Third Avenue 10f. Zip Code 21784	11	10g. Citizen of What Country? USA			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment of Health and Mental Hygiene. In the Medical Examiner must be notified at once, To Re Completed by Eumeral Director.		1. Marital Status 1. Never Married 2. Married 1. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2. X No If Yes, Sive Year or Dates: 1. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give Note that the complete of the comple	Puerto Rican, etc.)	White, etc.	rican Indian, Black, hite //industry		
5-0036 style within 72 hours aft tygene. other than "natural" the Medical Examine	nanaldii	Elementary/Secondary (0-12) Coilege (1-4 or 5+) Coilege (1-4 or 5+) homemaker		domestic			
215-00 be filed win that Hygier riked other ent, the M	1		s Name (First, Middle, M Briscoe	Maiden Sumame)			
MD 21 12 should th and Mee to 27 is mau	2 1	9a. Informant's Name/Relationship (Type, Print) Sara Edwards (daughter) 19b. Mailing Address (Street and Num 3381 Riviera Lakes	ber or Rural Route Num S Vt., Boni	nber, City or Town, Stata Bay, FL	te, Zip Code) 34134		
imore, Pages I and ment of Heal tant: If item or other tra		10a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	Date 4-3-08	Sykesvill	e, MD		
Balt permit. Departi Importinjury	1	Page Address of Facility Page Address of Facility Page Address of Facility P.O. Box 195 St	ykesville,	MD 21784			
Physician /Medical xaminer	1 0	3a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as can failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) a. Small bowel dostruction with complication but to (or as a consequence of): Sequentially list conditions,		est, shock, or heart	Approximate Interval Between Onset and Death		
The second of th	EXAMINE	f any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):					
Division of Vital Records, P.O. Box 68760, To the Hospiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ysiciani/imedical	d. XUNPENDED AMENDED 23a,PTI,27,cer/ME,g880 6/27/08 TT FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown JAMENDED 23a,PTI,27,cer/ME,g880 6/27/08 TT 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	c pregnancy	23d. Date of delive	ery Day Year		
Division of Vital Records, P.O. Box 687 and or Attending Physician: The law requires that the death certific and birector: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the difference of the Physician In the Physician In the Interior of the Computation by Division In the Interior of th	Completed by Fil	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa Hypertensive atherosclerotic, chronic obstructive pulmonary disease	1 Ye 24a. Was autor	an 24b. Were prior to death	robably 4 Unknown autopsy findings available b completion of cause of		
tal Reciant The	ນ 2	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other;					
Division of Vital To the Hospital or Attending Physician, within 24 hours after death. To the Funeral Director. After this certificompletely filled in by the funeral director,	2	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 28b. Time of Injury (Month, Day, Year) 1 Yes 2		Residence 6 Oth	ner:		
Division o spital or Attending hours after death. neral Director; After filled in by the fune		Suicide 6 Could not be determined Could not be determined (Specify)	or Town, S	State)	Rural Route Number, City		
To the Hospital within 24 hours To the Funeral completely filled	ealcar	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death ocand manner stated.	ace, and due to the causticurred at the time, date	and place, and due to	the cause(s)		
o o pend		29b. Signature and title of certifier 29c. License number O.C.M.E.	OCME	29d. Date signed (A	Month, Day, Year)		
Ø		10. Name and address of person who completed cause of death (15th 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Ba	Itimore, MD 2120	1			
Stat Registra	~	APR 0 4 2008 2. Registrar's Signature					
DHMH II Rai 1,200	4	ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2255 008 /Medical Faejlity Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Medical If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 07 26 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 M 2 □ F 250.46.1452 SC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Road 21215 Bareva by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Mes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Elementary/Secondary (0-12) College (1-4or 5+) Worker 100grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Jones lurner ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Road Baltmore MD 21215 Bernice Tumer Bareva 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 Removal from State 0410 08 Owings Milb, MD survison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn (. Green's Funeral Senico 21. Signature of Funeral Service License Vayahn Road Randall stown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and requires that the death certificate be executed Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 autopsy performed2 certificate 1□ Yes 2 H No or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 🗓 Vo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month

7°2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 28b, f per me, g878, 04/03/03dbb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 919 PM 1 HOMPSON EB AMES 8005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HRLY TEDICAL LORE ALTI ノレシヘブモンド 8. Date of Birth (Month, Day, Year) June 17, 1 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 ☑ M 2 □ F 70 213-32-7299 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2043 Beechwood Avenue 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after Hygiene. 1 X Yes 2 No If Yes, Give Year or Dates: ¹57-59 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unit 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H 7 is marked ott Be James D. Thompson Sr Lillie Mae Sampson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun 4416 Wentworth Avenue Baltimore, MD Cheryl Cooper/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Spacify) 21. Signature of Funeral Service I censes ROTHER AND MAN State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Immediate Cause (Final disease or condition resulting in death) Cral **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 No Division or Vital Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury
(Month, Day Year)
28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 2 1. Location (Street and Number or Rural Route Number, City or Town, State) 2043 Beechwood Ave. Baltimore, MD 4 Homicide HOME 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) APR 0 3 200 32. Registrar's Gignature

30. Name and address of rorson who completed cause of death (Item 23a) (Type, Print)

PAUL PLACE BACTIMORE MA LIZUZ

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	faryland / D	epartme Certifica			nd Mental I	Hygien	Z 11117	3 11127		
			1. Decedent's Name (First, Middle						2. Date o	Death	ay Yea	3. Time of Death		
	Physici /Medi		John R. U.	Henreith	er				agein	0 /	20	08 5: 40 AM		
7	Examir	er	4a. Facility Name (If not institution		r)			Location of	Death	4	c. County of D			
		- 1		muell			Salta		IA Use		Dalte			
п	Funeral Director		5. Social Security Number 214 10 0462	6. Sex 7. A	ige (In yrs. last birt) 93 Y	rs. Month	er 1 Year S Days	If Under 2 Hours	Min. 8. Date o	Birth Day, Yea. 1914	r) 9. Ma	Birthplace (State or Foreign Country) YYI and		
	p _		Usual Residence of Decedent						12/20/	1311				
	death with the Maryland ms 23a or 28a-f show froust be notified at	7	10a. State 10b. County		10c. City, Town							10d. Inside City Limits		
	the M	Director	MD N/A 10e. Street and Number		Baltimore		S- Ondo			10- 0	1141 4 1411	1 ∑ Yes 2 □ No		
	with the contract	급					ip Code 1224				itizen of What	Country?		
	heath	Funeral	3018 E. Fayette St	12. Was Deceden	t Ever in U.S.			spanic Orig	in? (Specify Yes o	U.S		mencan Indian,		
9	or Itar		1 Never Married 2 X Marri	Armed Forces ed 1 ☐ Yes 2 🔯	?	If Yes, sp	ecify Cubar	n, Mexican,	Puerto Rican, etc.)	Black, W			
21215-0036	n 72 hours after death with the Marylan "natural", or Itams 23a or 28a-1 show wolkal Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1 ⊔ Yes	2 🔀 No	Specify:			Specify:	White		
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12	withir ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 8 College (1-4or 5+) Blacksmith						Ste	rool				
	Hygi Hygi other ant, t	a)	17. Father's Name (First, Middle,	Last)	DIC	CKSIII GT		18. Mother	's Name (First, Mic					
Maryland	ges 1 and 2 should be filed within 1 of Health and Mental Hygiene. If item 27 is marked other than "I or other traumatic event, Ite Mes	To B	John N. Uttenreith	John N. Uttenreither Lily Welk 9a. Informant's Name/Relationship (Type, Print) Frances Hans, Sister-In-Law 505 N. Essex Avenue, Baltim										
lan	2 sho and N is ma	•									or Town, State	e, Zip Code)		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation	3 □Removal from State	20b. Place of cemetery	Disposition (N , crematory o	ame of other place	9)	Date	20c. I	Location - City	or Town, State		
Ë	permit. Pa Departmen Important: any injury		`4 □Donation 5 □Other (S)		Hilltop		1		4/03/2008		ison, Mar	yland		
Bal	Department Department of the second of the s		21. Signature of Funeral Service I	Licensee		1		s of Facility		ard J. Ruck, Inc.				
37.7	10-31-1		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. Do no				Baltimore, ardiac or respirato		.14	Approximate		
	Dhysisian		Immediate Cause (Final	only one cause on each	line.			,,		,		Interval Between Onset and Death		
7	Physician /Medical		disease or condition resulting in death)	a Neum	s a consequence o	·}-						weeks		
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Ä.	death d for u	Physician/Me	in the past 12 months?	4☐Pregnant a	2 Fetal death	3 ☐ Ectopic 5 ☐ Other (_	Month	Day Year		
P.0	that the de led by the a detached	hys	9 🗆 Unknown	9□ Unknown										
	res tha igned b		Part II. Other significant conditio	ns contributing to death	but not resulting in	the underlying	cause give	n in Part I.	23e. C	id tobacco		to the cause of death?		
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	F 3 F 8) (1)1-0- w	01.										
	1		30. Name and address of person v	who completed cause of	death (Item 23a) (T	vne. Print)	1 51	2 95			4/2/0	8		
	5		1 , 101	mo 670	1 N Ch.	cols S	7 5 w	the 4	202 7.	wsn	n	d 21204		
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DHMH 17 Rev 1/2001

08-02609 Howard White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ward White		1- For State	ate of Maryla	•	artment of tificate of		and	Menta	al Hyg		eg. No.	200	18	1112	
Physicia	n/	Registrar 1. Decedent's Name (First, Middle Control of the Contro		-					2	. Date of Deat Month		Year		of Death	
edical Exami	ner	Howard L. Whi		(mb os)		b. City, To	un orlo	eation of I		April 2, 20	08	County of Deat		1 hrs	
		University Hospital	n, give street and no	annoer)		Baltimo		ocation or i	Dodiii						
Funeral		5. Social Security Number 216-62-1548	6. Sex	7. Age (In yrs. I	ast birthday)	If Under		If Under		4Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign					
Director		210-02-1340	1 XX M 2 F	52	Yrs.	Months	Days	Hours	Min.	06/	18/		ountry)	MD	
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nth witl	Funeral	11. Marital Status 1 Never Married 2 XXM				Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.							an, Black,		
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215-0036 be filed within 7 ral Hygiene. Red other than	Com	17. Father's Name (First, Middle,	Last)		<u> </u>		18	3.Mother's		First, Middle, I					
215 be file ntal He rked o	Be	Howard L. W	<u>*</u>							othy P					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	리	19a. Informant's Name/Relations Darlene M.		ſfe	1 -		,			iral Route Nur .timore		ty or Town, Stat	e, Zip Co	de)	
e, MD and 2 sho fealth and item 27 is traumati		20a. Method of Disposition		20b.	Place of Disposi	ition (Name				Date		Location - City o	r Town, S	State	
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Baltimore, permit. Pages I are Department of Hee Important: If itenigary or other tr		4 Donation 5 Other Spanish	Licensee Vict	or P. D	oda 22. N	lame and A	ddress	of Facility(Char	les L.	Ste	vens F.	H.,	Inc.	
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/iSiC r Atter ter dea irector	ficat	2 V Accident 3 Suicide 6 Could not be determined (Specify) Local Street 4 Homicide (Specify) Local Street 1 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1000 Block of East Patapsco, E									and Number or F	Rural Rou	te Number, City		
Division or Attent hours after death meral Director:	Certification:										Patapsco, Ba	timore,	Md.		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner:On the basis	est of my knowled s of examination a	ige, death occur and/or investigat	rred at the t	ime, dat opinion,	e and place death occ	ce, and our	due to the cau	se(s) ar and pla	nd manner as sta ace, and due to	ated. the cause	e(s)	
To the To the To the Comp	Medical	29b. Signature and title of certific	and manner	stated.					OCME		_	Date signed (N			
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10		3/. Name and address of person				=				ME a := :					
		Theodore M. King, Jr. 31. Date filed (Month, Day, Year)		ant Medical		111 Pei	nn Stre	eet, Balt	timore	, MD 2120	1				
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			For State Registrer	State o	f Marylaı	nd / Depa <i>Ce</i> a	artmer <i>rtificat</i>				1ental Hy	gie Rag.	2000	3	11129
	Dhyaiai		1. Decedent's Name (First, Middle	Last)							2. Date of De Month		Day Ye	ar	3. Time of Death
	Physici /Medio		Robert	Fr	ank		Warne	er			April		2008 Ye		10:40 P M
	Examin	er	4a. Facility Name (If not institution,					_	Location o				4c. County of Death		
			Harford Momoria 5. Social Security Number	L Hospita _{6. Sex}		. last birthday)		r 1 Year	e Gra		9 Date of Bi		Harford		lace (State or Foreign
	Funeral Director		231-20-7848	0. 30X 12 M 2□F	7. Age (III yrs	81 Yrs.	Months		Hours	Min.	8. Date of Bi	12. Ye	926 Fr	Coun	Linville,NJ.
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	yland		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1	0d. Inside City Limits
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	iff the	Director	10e. Street and Number				10f. Zij	Code				10g. Citizen of What Country?			
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	er de	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie	Amed Fo	edent Ever in U proes?	U.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	igin? (Spi n, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - A Black, V		
36	rs aft	by F	I □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 1 □ Yes 2 ☑ No Specify: Year or Dates:									Specify: White		ce	
9	72 hours after death with the Maryland nature!', or items 23s or 28s-f ehow lisel Examinar must be notified at	led	15. Decedent	s Education		16a. Dece	dent's Usu	al Occupa	ation			16b	. Kind of Busine	ess/Inc	dustry
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21	filed with Hygiene. Ither ther	Completed	9 years			Po	lice	Offi					thlehem	St	:eeT
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yla	D 2 2 0	ဥ	Hiram Bronson W								lie Mel				
Maryland	har 7 is		19a. Informant's Name/Relationsh Sharon Beazley	_{ip (Type, Print)} Dauqht	er	19b. Maili 331	ng Addres: Glenv	s (Street a 'ille	Road	er or Rura 1, Ch	al Route Numb lurchvi	er, Ci 11e	ity or Town, State	210)28
-	is 1 and 2 of Health item 27 l		20a. Method of Disposition			Place of Dispo	osition (Na	me of		7	Tate 7,	200	. Location - City	or To	wn, State
OL.	ages ant of nt: If i		1 ☐ Burial 2 ZCremation 4 ☐ Donation 5 ☐ Other (Sc		State Ba	cemetery, crei LVVIEW	_			Apri 200	-	Ra	ltimore	. IV	Maryland
Baltimore,	ortar				0			_						•	
ä	permit. Pages 1 a Department of He Important: If item any Injury or oth once.		21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundal 7110 Sollers Point Road, Dundal												21222
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that coniv one cause on e	aused the dea	ath. Go not en	ter the mod	de of dyin	g, such as	cardiac	or respiratory a	arrest,	•		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Dr	781111	11011	1.4								Onset and Death
	/Medical		disease or condition resulting in death) a. ULUVI EVV 4 Due to (or as a consequence of):												
	Examiner		Gequentially list conditions h Republic Fair Con												
\.	bed isit	Examine	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
20	be executed sicien and burial-transit	xan	that initiated events resulting in death) Last	c. Due to	or as a conse	que j e of):	un	W.	$\gamma - 1$	$\mathcal{U}(\cdot)$	Carri	~		+	
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9	uficete t g physi es the b	ed													
Вох	eath certifi ettending for use es	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregr		∃Ectopic p	regnancy					23d. Date of		,
	e deal	scle	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of		Other (s						Month		Day Year
P.0	that the de ed by the detached	Physician/Me	9 Unknown					-		-	non Did	4-1	<u> </u>		
	89 US	þ	Part II. Other significant conditio	ns contributing to a	eath but not re	sulting in the u	inderlying (cause give	n in Part I	•				e to tr] Prob	ne cause of death?
ő	w requir been s should	etec													· -
Vital Records,	The law ete hes page 2 :	ompleted									24a. Was		prior	to cor	psy findings available mpletion of cause of
a		ပို	25. Was case referred to medical						00 Bloom		1 Yes	2 🕽	No 1□	Yes	2 □ No
	Physician: this certific ral director,	0 B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DX	Othe	200		h Check only		e 6 □Other (Snacif	w)
0	erthii		27 Varietr of Death	28a. Date	ol Injury th, Day Year)	28b. Time o		28c. Injun Work			28d. Describe			эрвст	7
jo	Attending Ir deeth.	atle	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	in, Day real)	Injury	М		Yes 2	No					
Division of	ial or Attendii s efter deeth. bl Director: A ed in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 288. Place	ol Injury - At I	home, farm, sti	reet, lactor	y, office			28f. Location City or To			r Rura	l Route Number,
	To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b		29a. Certifier 1 Certifying	Physicien: To the	best of my kn	nowledge deat	h occurred	at the tim	ne, date an	nd place	and due to the	Calle	e(s) and manne	r ac ci	tated.
	he Hoo n 24 h he Fur pietely	edical		xaminer: On the b	asis of examin ner stated.	nation and/or in	vestigation	in my o	pinion, dea	ith occur	red at the time	, date	and place, and	due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	/	11 7		29	c. License	number	//	/	29d.	Date signed (M	lopth,	Day, Year)
			771	u /	W.D.		1	12	96	6	1	7	15/0	28	ζ
	6		30. Name and address of person v	who completed caus	se of death (Ite	т 23а) (Туре,	Print)	ارما	1	-/-	finn		A Gr	n	o MD
	Sta	te	31. Date filed (Month, Day, Year)	32. F	legistrar's Sign	nature	ill	on	24	_ N	VIC	0	w 71	u	2107A
	Registr		APK U 1 ZU	10 Jacob	2 15	San Contract	The state of the s								21-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ERRSA INAX 12:108 2008 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, March 7, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months 1 ☐ M 2 🗓 F 216-01-3239 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21234 2412 Perring Woods Road USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify White ð 3 ☐ Widowed 4 ☐ Divorced led Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Complet Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelo DeSantis Rosaria Patullo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angela Kurek/Daughter 4403 Camella Road Baltimore Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 4/7/08 Baltimore Maryland Léonard J. Kück, alik 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses husten Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4□ Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Ribillation 2 □ No 1 ☐ Yes 2 No 1 TYes 25. Was case refer to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4☑Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide

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attending physician and for use es the burial-transit Physician/Medical Be f Director: After this d in by the funeral of Certification:

or Attending Physician: The law requires that the death certificate be executed

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within 24 hours e To the Funerel C completely filled i Hospital

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Medical

P.O. Box 68760,

Division of Vital Records,

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28a-f ehov

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Important: If Ite
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/ Physician

/Medical

Examiner

the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

4 | Homicide

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier 29c. License number

D28187

BALTO.

29d. Date signed (Month, Day, Year)

30. Name and address of person to completed cause of death (Item 23a) (Type, Print)

SPERLING 31. Date filed (Month,

5601 32. Registrar's Signature

LOCH RAVEN BLO media

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 28, 9:00 PM Woods March 2008 Roger 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death TOWSON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Month, Day, Baltimore Stella Maris Hospice Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months 1 X M 2 □ F 213-34-3948 29,1938 Óhio 70 March Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 ☐ No MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6926 Birdwood Avenue 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify Specify: 3 ☐ Widowed 4 ☒ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Woods Lucy Raike 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Birdwood Ave., Baltimore, MD 21220 James D. Borror/Brother 6926 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∏Donation 5 ☐ Other (Specify) Howard University : 4/3/08 Washington, DC 21. Signature of Fune al Service Lic 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, NW, Washington, DC 20011 23a Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause to the district Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? rt I. 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 25. V

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it will be mortified any proper.

Baltimore, Maryland 21215-0036

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Maryland

attending physician and for use as the burial-tran signed by the a icate has been si, page 2 should b 124 hours after death.

e Funeral Director: After this certificate loletely filled in by the funeral director, pag

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

ROGER WOODS

Examine Physician/Medical δ Be Completed Medical Certification: To

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27. N

9 Unknown	9 🗀 Unknown
Part II. Other significant condition	ons contributing to death but not resulting in the underlying cause given in Pa

									per 1 □ Yes	formed? 2 💢 No	death? 1 ☐ Yes	2 🗆]No	
as case referred to medical aminer?							26. F	Place of Death	(Check only	one)				Ī
∐Yes 2 ∑ N	0	Hos	pital: 1	ER/Outpatient	3 🔲 [OOA Oth	ner: 4[☐ Nursing Ho	me 5 ☐ Res	sidence	6 X Other (Spec	cify)	HOSPICE	
anner of Death Natural Accident	5 Pending investigation		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Inju Wor 1 □		2 □ No	28d. Describe					
☐ Suicide ☐ Homicide	6 ☐ Could not be determined		28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fy)	facto	ry, office			28f. Location City or To	(Street ar own, State	nd Number or Ru e)	ral Ro	ute Number,	

ı	2 Accident	investigation		M 1 □Yes 2 □No						
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, street, factor	28f. Location City or T	28f. Location (Street and Number or Rural Route Number City or Town, State)				
	29a. Certifier (Check only one)	1X Certifying Physi 2 Medical Examina	clan: To the best of my know er: On the basis of examinat and manner stated.	vledge, death occurred ion and/or investigation	d at the time, date and plan, in my opinion, death of	ace, and due to to ccurred at the tim	ne cause(s) and manner as stated. e, date and place, and due to the cause(s	;)		
	29b. Signature and	title of certifier)	29	c. License number		29d. Date signed (Month, Day, Year)			
l			/		D4372.	5	7.12/08			

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093

State Registrar 31. Date filed (Month, Day, Year)



within 24 hou

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death Month **Physician** 2008 /Medical acility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** arro 5. Social Security Number 8. Date of Birth May 20, 1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Hours Min. Country) 551-16-0654 89 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Berlin Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6912 Rum Pointe Road 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Engineer Department of Energy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Edward Weber Florence Ross မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary R. Weber (Spouse) 6912 Rum Pointe Rd., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If ite
any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 4/5/2008 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License HATCHTO FUNERAL HOME & CHAPEL, M00764 Box 195. Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stage **Physiclan** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) nis certificate has been signed by the a director, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) 2010 Hospital 1 Yes Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No death. s after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours af To the Funeral D the Hospital 1 Scertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature d tite 29c. License number 29d. Date signed (Month, Day, Year) Q_j 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 159 & Idersbum illiam Tan MD 1645 bert 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 7 2008 APR 0 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** $\underline{A}^{\mathsf{M}}$ ALI YEGANEH APRIL 03 2008 2:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days 1 X M 2 □ F 549-53-7844 55 5, **Director** Feb. 1953 Iran Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2627 East Joppa Road Funeral <u> 21234</u> 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent years Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mahsultan Gahledar <u>Ali Morad Yeganeh</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryam Yaganeh (wife) 2627 East Joppa Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Cardens 4-4-08 | Timonium, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician AsoMathan /Medical Due to (or as a consequence of): Examiner Brack Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sinsequence of): The law requires that the death certificate be executed burial-transi myotrophic gg/ Due to (or as a consequence of): P.O. Box 68760 been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA after death. I Director: After this of in by the funeral di 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Within 24 hours are. To the Funeral Dir. 1 detail Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00061886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 ner senjamin 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month **Physician** TWIEBELMAN AM08 /Medical 4a. Facility Name (If not institution, give sweet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS MILLERSUILLE ANNE MANOR NOLLWOOD Social Security Number Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
05-13-19 7. Age (In yrs. last birthday) **Funeral** 33-20-1448 Months Days 1□ M 2**X**F 89 Yrs. Hours Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 X No Director Millersville Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 899 Cecil Ave. South 21108 USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 XWidowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygien Important: If item 27 Is marked other that any injury or other traumatic event, the the Unknown Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္ Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Schulte (Administrator) 899 Cecil Ave. South Millersville, MD. 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Service Corp. 04/03/2008 Towson, MD 22. Name and Address of Facility Dula-Ruck Funeral Home of Hilltop Service Corp. 04/03/2008 21. Signsture of Funeral Service Lip Wise Ave. Dundalk, MD. 21222 Dundalk, Inc. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONI **Physician** WEEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Extra to be a greater that initiated events resulting in death) Last Due to (or as a consequence of) Examine and the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the s 9☐ Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2**X** No 1 ☐ Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page certificate Vital 2□ No 2 No 1 ☐ Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) o After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural
2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No M investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

KILBRIDE RD, BALTIMORE, MD 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 0

7 2008

ACE (M)
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amen Items 23a,25,27,28a-f per man 2878,0403/08dhb
Red. No. Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 45PM Physician -corlary 2 2008 Catherine Zarbos /Medical 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number) Examiner tealth and If Under 1 If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Funeral Months Davs 1 ☐ M 2 🂢 F Maryland 08-23-1915 212-18-3215 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Sparrows Point Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21219 2825 Lodge Farm Rd Apt 214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify: þ White 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 is marked other tht any Injury or other traumatic event, the Waitress Restaurant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Zarbs Mary (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 503 Cedarwood Ct Bel Air, MD 21014 Allan J. Zarbos, Sr. (Son) Baftimore, 20a. Method of Disposition
1 □ Burial 2 🖺 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 02-07-2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 au a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Physician /Medical Due to (or as a consequence of) **Examiner** Preymonio Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, MEDICAL EXAMINER Examiner death certificate be executed and burial-trai (TION MOP Due to (or as a consequence of): CERT Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Ö that the ئە Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hip fracture 2¥ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Vertebral 24a. Was an page 2 s 1□ Yes Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division or this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Hospital or Attending latural 5 Pending investigation 12/14/2007 Unknown Subject fell 1 Yes 2 No 2 Accident n 24 hours after death. ne Funeral Director: A bletely filled in by the fi death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing Hone 3 ☐ Suicide 28f. Location (Street and Number of Rural Route Number City or Town, State) 410 E. MacPhail Rd. determined 4 ☐ Homicide Bel Air,Md Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. completely 2 Medical Exa To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0063981 2008 07 w. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harrede Grace, MD 669 Revolution St. Benjamin Lee, MD 31. Date filed (Month, Day, Year) 32, Registrar's Signature State APR 0 3 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery Hebrew Home if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours 1 ☐ M 2 🔀 F 93 235-38-0494 09/28/1914 Bluefield, WV Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County aţ 1 ☐ Yes 2 No Rockville 28a-f sh notified Md. Montgomery Director Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28aunt or other traumate event, the Medical Examiner must be notifi 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20852 U.S.A. 6121 Montrose Rd. Completed by Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leander Α. Robinson Mary Hix 2 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20706 Tricia Yvonne Alston-5600 Whitfield Chapel Rd.Apt#301Lanham, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it any injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/14/08 Laurel, Md. Maryland National 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Se Me License 411 Kennedy St., N.W. Washington, DC20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Detal death 1 Live birth Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nas autonsy perform Yes 2 2000 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Minur of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier

of D

31. Date filed (Month, Day, Year)

MAR 1 7 2008

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyggiene State 19b Registra amended # 25, 2 per FH 7,28as perDME Certificate of Deathfchd3/7/08 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** June A. Albaugh 2008 March 11:53a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Par If Under 24 Hr Bys Hours Mir Frederick 5. Social Security Number 212-24-3741 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 79 Davs 1 □ M 2 🖫 F Director 30,1928 April Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Frederick Maryland Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5548 Etzler Road 21702 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: **A** Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Etzler Lillian Hamilton Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 sh nt of Health and : If item 27 Is n 5548 Etzler Road, Frederick,MD 21702 Thomas Albaugh/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or injury or Mt. Olivet Cem 3/05/2008 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home Rolorson 1621 Opossumtown Pike, Frederick. MD 21702 art. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of the rt failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MOKING if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 RIGHTHIPFARCINA 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death?

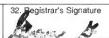
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed' 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: do Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 2/4/08 1 Yes 2 No Fell while pushing cart death. 2 Accident 1700 after death. pletely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide CVS Retail Store Frederick, Maryland To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and the o 29d. Date signed (Month, Day, Year)

3

State Registrar

31. Date filed (Month, Day, Year)
MAR 0 7 2008

Dr. Ronald Miller



Culwell Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sture

Meeks

Mt. Airy,

MD 21771

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** OMA JEAN ADKINS 03 2008 20 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner WASHINGTON NMS Health care of Hagerstown Hagerstown Birthplace (State or Foreign Country) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 04-04 7. Age (in yrs. last birthday) If Under 1 5. Social Security Number **Funeral** Year 1 □ M 2 1 F Months Hours Min. 224 345721 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location sa or 28a-f show t be notified at 1 Yes 2 No Director NONE Winchester VA 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with t Hygiene. ither than "natural", or items 23a or ? 22401 USA 2924 ms 23a Grace Funeral . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items Black. White, etc. "natural", or iten adical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify CAUCASIAN Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FACTORY PRODUCTION WORKER d 2 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NANNIE MARTIN TIMOTHY SPARKS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PATSY J. BROWN - DAUGHTER 1171 W. PARKINS MILLRD. Winchester, VA 22602 Department of Health a Important: If Item 27 is any Injury or other tra of Health 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Pages 1 Shenandoah Mehibi L PALK MHUSOLEUM CHAPEL 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03-22-2008 Winchester, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility & HOME 415 E. Wilson Blake, Hoge from 21. Signature of Funeral Service Lice nny In 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 64 Physician ementi /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran Due to (or as a consequence of) Box 68760. physician pe Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | 9☐Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: Hospital: 2**52**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes P funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attend 24 hours after death. Funeral Director: 2 Accident death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21740 -0H-5 heD, MD tarid 32. Registrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mar 14, 2008 10:05 P M Lessie Stephens Bohlman 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Adelphi Hillhaven Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 ☐ M 2 🖾 F Mar 26, 1923 Anderson, 248-20-2026 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1X Yes 2 □ No Virginia North Umberland Callao 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 22435 240 Quinton Oaks Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 Yes 2K No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Printing Specialist 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ida Eucary Mitchell John Thomas Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Quinton Oaks Lane, Callao, VA 22435 Barbara Shine - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 3/18/2008 Fort Lincoln Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4739 Baltimore Ave. 21. Signature of Funeral Service Licenses Gasch's Funeral Home, P.A. Hyattsville, MD 20781

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Funeral

Director

if flem 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinal mast be retified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic avent, It a Madic once.

Baltimore, Maryland 21215-0036

burial-tran and

Division of Vital Records, P.O. Box 68760

	shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. Demension		y13	
	Tosulang in doutiny	Due to (or as a consequence of): (0/0/0/0/V) AMENT DISCOR		VICE
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Of O A Y A Y I S T A I S C			χ/ ∫.
ysician/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	12 months? 4 Pregnant at time of death 5 Other (specify)		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
completed			performed? death?	utopsy findings available completion of cause of 2 No
De.	25. Was case referred to medical examiner?	aminer?		
0	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)		
ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work?	Describe how injury occurred	
Certification	3 Suicide 6 Could not be 4 Homicide determined	286. Place of injury - At nome, farm, street, factory, office 201. L	ocation (Street and Number or R City or Town, State)	ural Route Number,
edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
				2008
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DHMH 17 Rev 1/2001

State

Registrar

Nade 31. Date filed (Month, Day, Year)

MAR 2 0 2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MARCH 18. 2008 12:15 P Charles R. Burkley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's New Carrollton 8509 Caswell Place 6. Sex XXXM 2□ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 14, 1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 577-28-7569 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examination mat be matthed at 1 □ Yes 2XXNo New Carrollton Director Prince George's Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8509 Caswell Place USA 20784 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? Retired 1 Never Married 2XXMarried White Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽ No Specify: Be Completed by If Yes, Give Year or Dates: 1961 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "n any injury or other traumatic event, the Media 2008. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navv Chief Petty Officer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Henry Burkley Grace Deavers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8509 Caswell Place New Carrollton, Maryland 20784 Mary A. Burkley / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XX urial 2 Cremation 3 Removal from State St. Paul's Episcopal Ch. Cem 03/22/2008 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 21. Signature Funeral Service Lice 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland Phys. Enter the disease or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau is on each ling. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician IF FEMALE: 23c, If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be SRYV 1'S Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DQA Other: 2 1 ☐ Yes 2 No filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Diractor: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide Sunaral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riad Dakeel MD 8100 Mitchelville Road #406 Bowie, Maryland 31. Date filed (Month, Day, Year) State Registrar 2008 DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** 6:13P M MARCH 14, THORNTON JERRY BARNES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Director 226-52-7879 66 03-26-1941 Virginia Usual Besidence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George's Capital Heights MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 20743 310 Zelma Avenue d 2 should be filed within 72 hours after death vith and Mental Hygiene. 7 is marked other than "natural", or items 23s Traumatte event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 21 No Specify: ۵ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Ashton Frank Barnes ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. 20743 Capital Heights, MD 310 Zelma Avenue Talatha Barnes/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Salem Church Cemetery | 03-20-2008 Montrose, VA MARSHALL S FUNERAL HOME OF MD/WELDON-FISHER F.H. DOWALD 2. GRAY 4308 SUITLAND ROAD SUITLAND, MD/ OLDHAMS, VA 23a. Part 1 Inter the disease shoot, or heart failure. List e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Malignont Merchelisma **Physician** /Medical Due to (or as sonsequence of): Examiner Sequentially list conditions, it is a year of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Ses 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

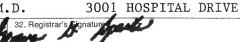
Medical

DANIEL ALEXANDER, M.D. 31. Date filed (Month, Day, Year) MAR 2 0

4 ☐ Homicide

29b. Signatore and title of certifier

29a. Certifier



Songe MD

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

3

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D52815

29d. Date signed (Month, Day, Year)

CHEVERLY, MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** $\operatorname{\mathbb{P}}^{M}$ EDITH MAE BEASLEY 22, 2008 2.30 March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 M 2 X F 74 July 22, 1933 Indiana Director 295-28-9729 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2K No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2507 Shelley Circle Unit 2-A 21702 United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: ģ 3 Widowed 4 Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Geriatric Nursing Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental I permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked of any Injury or other traumatic eve ဥ Frank Harrell Emilie Ritterbusch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2507 Shelley Circle Unite 2-A Frederick MD 21702 Michael K. Beasley/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc 3/24/2008 Frederick, Maryland 21. Signature of Fineral Seg 22. Name and Address of Facility Stauffer Funeral Homes P. A. 621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRU CTIVE LUNG DISEASE CHRONIC **Physician** UNKHOWN /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ig physician and as the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURF 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate has birector, page 2 s 2 No 24 hours after death.

E Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide determined 4 ☐ Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Box 68760, P.O. I Division or Vital Records, Hospital or Attending Physician: within 24 hor To the Fune completely f

2

MD null 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29b. Signature and title of certifier

and manner stated

Dr. Florin Rusu 400 West 7th Street, Frederick, Maryland 21701 31. Date filed (Month, Day Ward 2 5

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

058808

29d. Date signed (Month, Day, Year)

0312,3108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 20 2008 4:00 Robert March Ε. Baudrau /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick 8001 Mills Manor Court Thurmont 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 82 579-24-6484 July, Connecticut Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a, State 10b. County 1 □Yes 2 No Director Thurmont Maryland | Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code hours after death with an "natural", or items 23a Medical Examiner must b 21788 United States 8001 Mills Manor Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 □ Widowed 4 □ Divorced Year or Dates: Completed Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu, any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Power Engineer Country Club 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Joseph Baudrau Lillian Adams 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8001 Mills Manor Court Thurmont, Maryland 21788 Charlotte Baudrau / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State March 25 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 22. Name and Address of Facility Stauffer Funeral Homes, P.A. peral Service Licensee 1621 Opossumtown Pike Frederick, Maryland, 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive YEARS **Physician** /Medical Due to (or as consequence of): Pulmonary Direase Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit MONTHS. Cevehrovarcilar Due to (or as a consequence of) Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed? page 2 s certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 💢 No မ this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. spital or Attendi ours after death. neral Director: A 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 00062223

10+1

State Registrar

DHMH 17 Rev 1/2001

196 7J DRIVE, FREDBALCK, MD 21703

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Registra

PLAYECH BIGHTHUM

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 3. **2008** Patricia Bishop 1:30 p. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frederick 5660 Wade Court Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Months Days 1 □ M 2 XF 47 Sept 21, 1960 California 214-80-6000 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count Frederick Frederick Maryland 1 ☐Yes 2X No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21703 **USA** 5660 Wade Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married white 1 ☐ Yes 2K No Specify: 3 ☐ Widowed 4 → ivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Data Entry Clerk Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances White Leonard Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16 Lea Pond Court, Montgomery Village, Maryland 20886 Leonard Moore - father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3-7-2008 Germantown, Maryland All Souls Cemetery 4 □ Domation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Immediate Cause (Final Lar disease or condition resulting in death) Semo (EW) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or s Mellitus Type I that initiated events resulting in death) Last Due to (or as a ob IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□No 1□ Yes 2**X** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home SXXResidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 3□ DOA 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 🙀 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At hon building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Examiner Examiner that the death certificate be executed physician and the burial-transit Box 68760, Physician/Medical the 8 Ö signed by ٦ 2 Records. requires Completed aw has The certificate Vital Physician: Be Certification: To Division or this or Attending **Director:** within 24 hours a
To the Funeral C Hospital

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Physician

/Medical

Examiner

Funeral

Director

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ns 23a or 28a-f shov must be notified at

the Medical Examiner

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othany or other traumatic event

Physician

/Medical

Director

Funeral

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Completed

Be

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with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn J. Harrington, M.D.

2008

MAR 0 7

and manner stated.

11908 Darnestown Road, A&B 32. Begistrar's Signature

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0034163

29d. Date signed (Month, Day, Year)

North Potomaca Maryland

State Registrar 29a. Certifier one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15 Physician 26 2008 larch Barkdo narlot /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6. SKX 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In y s. last birthday) **Funeral** Months Days Hours Min. Yrs. 20, 1922 MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show adical Examiner must be notified at 1 Yes 2 No Director FL Lake Mount Dora 10g. Citizen of What Country? 10e. Street and Number 8034 St. James Way 32757 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be It of Health and Mental Joseph Omer Hennesy Lottie Ruth Daugherty ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Barkdoll/ Husband 8507 Mapleville Rd. Boonsboro, MD 21713 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Smithsburg Crematory 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 3-27-2008 permit, Page Department o Important: If any Injury or Smithsburg 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 TYes 3 Probably 4 Unknown No. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performe Yes 2 Vital Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To ō this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident d in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 ☐ Homicide n 24 hours aft ie Funeral Di iletely filled in 1 Toertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely the 29b. Signature 29d. Date signed (Month, Day, Year) 0 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 05H-7 San tussu 31. Date filed (Month, Day, Year) strar's Signature State 2008 MAR 2 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4:13PM March 2008 Charles Maynard BAKER 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 6. Sex J 1 M M 2 □ F Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 76 June 19 **Director** 1931 Maryland 214-28-5545 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 910 Pope Avenue 21740 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 117 Yes 2 □ No If Yes, Give Year or Dates: 1955-57 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fireman City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles M. Baker Margaret Ritter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice M. Baker - Wife 910 Pope Avenue, Hagerstown, Md. 21740

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Garden 3/27/08 Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atheroscle votic heart disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Renal failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Ventilatory Cailur and Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by diabetes Mellitus 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 M Inpatient မ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uniena M.D. March 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore. 05H-10+1 ALEJANDRO SEQUEIRA 32. Regitrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAR 2 6 2008

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	s Discosiosi		1. Decedent's Name (First, Midd	lle, Last)					2. Date o		ay	Year	3. Time of	Death
#	Physici /Medic		I	Karen K. Br	rown				Marc	h 2	2 20	008	6:25	ΡM
	Examir		4a. Facility Name (If not institution	on, give street and numb	per)		4b. City, Town,	or Location o	f Death	4	lc. County	of Death		
			Gilchrist Hosp:	ice			Towso				Balt	imor	е	
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days		Min. (Month	, Day, Yea	ır)	9. Birthp	lace (State o	r Foreign
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	pu:		Usual Residence of Decedent 10a. State 10b. County	u .	10c Cit	y, Town or Lo	cation		· · ·			1	0d. Inside Ci	ty Limite
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	with t	ā	10e. Street and Number	D			10f. Zip Code	10			Citizen of W		•	
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	Item Iner	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marital Status	Armed Ford	es?		If Yes, specify Cu	ban, Mexican	, Puerto Rican, etc.)		k, White,		
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	I If Yes, Give			1∐Yes 2 √Ç No	Specify:			Specify:	Whi	te	
Ö	2 hou atura cal E	ted	15. Decede	nt's Education			dent's Usual Occu			16b.	Kind of Bu			
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	be filed trail Hygid of other event, the	Be	17. Father's Name (First, Middle	, Last)				18. Mothe	r's Name (First, Mic	ddle, Maide	en Surnam	e)		
<u>la</u>	hould by Ments marked	P	Henry Komisare	k				Joan	Davis					
Maryland	S S S		19a. Informant's Name/Relation:				-		er or Rural Route N	-			,	
	1 and 2 Health em 27 I		Christopher Bro	own/Husband	,	4228	Columbia	Road	Ellicott	City	, MD	2104	2	
altimore,	of Hez of Hez fitem ir othe		20a. Method of Disposition 1 Darial 2 Cremation	3 □Removal from St	1 6	Place of Dispo cemetery, crei	sition (Name of matory or other pl	ace)	Date	20c.	Location -	City or To	wn, State	
E	Pag ment ant: I ury c		4 □ Donation 5 □ Other (rematory		3-24-2008		nover			
alt	permit. Pages 'Department of H Important: If Ite any injury or of		21. Signature of Funeral Service	e Licensee	M01	044 2	2. Name and Add	ress of Facilit	Harry H.	Witz	ke's	Fami	ly FH	Inc.
<u>m</u>	20 E # 9		Shan Colle	s-ucyay		4	112 Old	Co1umb	oia Pike 1	Ellic	ott C	ity,	MD 21	043
Р			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caust only one cause on each	used the deatl ch line.	h. Do not ent	er the mode of dy	ing, such as	cardiac or respirato	ry arrest,			Approximate Interval Bet	ween
9	Physician		Immediate Cause (Final disease or condition	2 6	UNI	CAN	CLA						200 5	jeath 2
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×	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outco	ome of precons	nev								
Bo	death of attended for us	ian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐Live bir	th 2 ∏ Feta nt at time of d	Ideath 3	Ectopic pregnan Other (specify)	су		- (3	23d, Date Mor	e of delive nth	-	Year
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ር	law requires that the as been signed by th 2 should be detache	유	Part II. Other significant condit	ions contributing to dea	th but not resi	ulting in the u	nderlying cause g	iven in Part I.	23e. I	oid tobacco	use contr	ibute to th	ne cause of d	leath?
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<u>a</u>			05.11/	-1					1 Y	es 2,27	No 1	□Yes	2 No	
or Vital	nding Physician: th. After this certifical funeral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	antiant OU	FD/Outrotion	4 0FI DOA 0	ther:	of Death (Check o.		. 60.		Unci	0111
o	Phy r this ral di	6	27. Manner of Death	28a. Date of		28b. Time o	IL S DOA	4 🗆 Nu	rsing Home 5 1 1 28d. Descr				n HOSI	74
on	dlng h. ; Afte	tion	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, igation	Day Year)	Injury	f 28c. Inji W M _1[orƙ? ∐Yes 2∐≀			,,			
Division	Attending r death. ector; After by the funer	lica	3 Suicide 6 Could	not be 28e. Place o	f injury - At ho	me, farm, str	eet, factory, office	•	28f. Locati	on (Street	and Numbe	er or Rura	l Route Num	nber,
ò	after Direction of in t	Certification:	4 ☐ Homicide determ	building	g, etc. (Specif	<i>y)</i>			City or	Town, Sta	ate)			
	the Hospital or hin 24 hours afte the Funeral Dit mpletely filled in			Ing Physician: To the b										
	ne Ho ne Fu ne Fu	Medical	(Check only one) Medica	I Examiner: On the bas and manne		tion and/or in	vestigation, in my	opinion, dea	th occurred at the t	me, date a	and place, a	and due to	the cause(s	i)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	M	29b. Signature and title of certific)			se number	0 -	29d. E	Date signed	(Month,	Day, Year)	
			101	1///	-			043	95	MA	MCH	20	, 200	8
(A)			30. Name and address of person	n who completed cause	of death (Item	23a) (Type,	Drint)							
17/	22		DANIEUE DOGET	rman, mo 6	545 N	ICHAR	US ST.	SMITE	209 BA	LITM	IFE!	NO C	21204	4
	Sta	- 4	31. Date filed (Month, Day, Year) 32. Ret	sistrar's Signa	ture								
ãã	Registr	rar	MAR 2	5 2008	Roller .	15 19	DEMES							
DH	MH 17 Rev 1/2	001				Contract of the Contract of th								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

00-02200	rieasery
Brenda Lea Branham	9

enc	la Lea Bran	1-	State of Maryland / Department of Health and Merital Hygin For State Certificate of Death	Reg. No.	008 1114
	Physicia		. Decedent's Name (First, Middle,Last)	Date of Death Month Day Year	3. Time of Death 1222 hrs
Pra	Examir		Brenda Lea Branham 4b. City, Town, or Location of Death 4c. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	March 21, 2008	Death
		4	101 Heritage Farm Circle Mount Airy	Carroll	
	Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.		9. Birthplace (State or Foreign
	Director		574 50 4226 1 M 2X F 48 Yrs. Months Days Hours Min.	04/06/1959	Country) Cuba
	_		Usual Residence of Decedent 10a State 10b, County 10c. City, Town or Location		10d. Inside City Limits
	ow any	- 1	MD Carroll Mt. Airy		1 Yes 2 X No
	Aaryland 28a-f show 1 at once	to -	10e. Street and Number 10f. Zip Code	10g. Citizen of Wha	t Country?
	the Ma a or 28 iffied a	Director	101 Heritage Farm Circle 21771		1 States
	ms 23s	la l	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Version of Hispanic Origin?) (Specific Version of Hispanic Or		American Indian, Black, etc.
	r death or ite	Funeral	1 Never Married 2 Married 1 Yes 2X No	Specify:	White
	rs afte ural", miner	۵	or Dates:	rk done 16b. Kind of Bus	iness/Industry
	72 hou n "nat al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Į.	- Duginaga
	036 vithin 72 ene. er than Medical	E I	1 Accountant	FIGUREAL First, Middle, Maiden Surname)	ng Business
	21215-0036 Juld be filed within 7 Mental Hygiene, marked other than c event, the Medica		Popald T. Calp. Vonnie J.	. Massev	
	212 wild be Menta mark c even		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	iral Route Number, City or Town	1
	nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland not Fleath and Mental Hygierier in of Fleath and Mental Hygierier in Flitem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once		Danielle Davis/Daughter 6570 Beechwood Drive C	Columbia, MD 27 Date 20c. Location -	L046 City or Town, State
	of Hea		1 Burial 2 Cremation 3 Removal from State crematory or other place)	4 2000 H	a MD
	Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within pepartment of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	1	4 Donation 5 Other Specify: Ardent Crematory 3-24 21. Signature of Funeral Service Licensee MOLO44 22. Name and Address of Facility Harri	4-2008 Hanovei rv H. Witzke's	
	Bal permi Depar Impo injur	- 1	Why Why 4112 Old Columbia I	Pike Ellicott (City, MD 21043
4.1	Chysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arrest, shock, or hea	Approximate Interval Between Onset and Death
	l ical _xaminer		Immediate Cause (Final disease a. Coronary Artery Thrombosis		Death
			or condition resulting in death) Due to (or as a consequence of):		
		힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
		Examiner	(Disease or injury that initiated events resulting in death) Last		
	50, te be executed sysician and burial - transit	ᇤ	d		
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Purneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	UNPENDED	23d. Date of	delivery
	Box 68760, e death certificate be the attending physic red for use as the burned	Ž	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Description of death	ncy Month	Day Year
	Sox 6876 death certificate e attending phy	sician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown g Unknown		
	O. Bo at the de 1 by the tached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		ribute to the cause of death?
	cords, P.C. law requires that has been signed be at should be deta		Hypertensive Cardiovascular Disease, Asthma		Probably 4 Unknown
	rds, requir	Completed by		autopsy	Were autopsy findings available prior to completion of cause of death?
	eco The law ate has	l mo		performed? 1 ✔ Yes 2 No	Yes 2 No
	tal Rection: The certificate ector, page	Be C	25. Was case referred to medical		✓ Other: Scene
	F Vit Physic or this	2	1 Yes 2 No 1 inpatient 2 Ervotipation 5 55.	28d. Describe how injury occur	
	on of adding Pl	io ii	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. tnjury at Work? 1 Yes 2 No		
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ris after death. The Director. After this certificate has been signed by lied in by the funeral director, page 2 should be deated.	licat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Numl or Town, State)	ber or Rural Route Number, City
	Div pital o ours aft eral D	Certification:	determined (Specify)		
	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this carificate I Completely filled in by the funeral director, page	g	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and the basis of examination and/or investigation.	d due to the cause(s) and manne at the time, date and place, and	due to the cause(s)
_	To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		ned (Month, Day, Year)
			Diam M Dinatinia	March 22	, 2008
6	0)0		30. Name and address of person who completed cause of death (Item 23a)	ID 04004	
()			Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	1D 21201	
		State			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month i 129 ZUUS /Medical 4a. Facility Name (If not institution, give County of Death Examiner LOVIEW Cersins Itales lines HOWEL 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Feb 13, 1 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours MA 79 Director 200 22 6714 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or thousany in other trainmat-10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12139 Gray Star Way 21044 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis W. Keith Marjorie Foley ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia B. Taliano/Daughter 12139 Gray Star Way Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3-24-2008 | Hanover, MD Ardent Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician VI 6 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 20 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) on who completed ca e of death (Item 23a

State Registrar 31. Date filed (Month, Day, Year)

MAR 25

2008

DHMH 17 Rev 1/2001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Day **Physician** 8:45 PM Gilbert Boyce 2008 20 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deatl 4c. County of Death **Examiner** Salisbury Wicomico If Under 1 Year | If Under 24 H 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F Days Hours Min 213-48-8679 **Director** 44 4/20/1963 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at other. Director 1 ☐ Yes 2 📉 No Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6949 Levin Dashiell Road 21830 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Baltimore, Maryland 21215-0036 DBlack, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Boyce CPA Company <u>certified public accountant</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warren Tyndall Boyce Joyce Rayner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joni L. Boyce/wife 6949 Levin Dashiell Rd., Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 3/25/08 Salisbury, MD A. Signature of Funeral Service Licenses 22.Nama and Address of Facility HOlloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Janes < CFSD Udominoro 3a. Part1. Enter the dise se, or complications I at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -1106/25/0MA disease or condition resulting in death) 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No certificate has autopsy perfor 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 ☐ ER/Outpatient 3 ☐ DOA Impatient this Date of Injury (Month, Day Year) Manner o Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 20 5:30 A.M Mary Isabelle Collins March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mt. Airy Carroll Lorien Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**XX**F 91 220-07-8795 Director July 14, 1916 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Frederick New Market MD 1 ☐ Yes 2X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21774 United States 5704 Deco Drive 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2/☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. þ Specify: 3√3√Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10th College (1-4or 5+) Sewing Factory seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Stump Mildred V. Howard Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5704 Deco Drive New Market, MD 21774 Jovce DiDio niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of the Important: If Ite any Injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery March 22, 2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ure of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 23a art1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im redian Cause (Final disease or condition resulting in death) Severe **Physician** /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physiclan and for use as the burial-tran Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown iting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: P 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P Certification: 1 Natural Injury To the Hospitar or within 24 hours after death.

To the Funeral Director: Aft

---totaly filled in by the fur 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier se of death (Item 23a) (Type, Print) Ave, D-1. FREDERICK, MIZITO, 101 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

MAR 2

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month Year 10:40a M March 20, 2008 Lawrence O. Carlson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 072-16-1192 1 □ M 2 □ F 90 Director Jan. 18, 1918 New York Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location of other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2407 Harmon Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: þ White 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Art & Design Education Acting President 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Otto A. Carlson Wendella Grandlund other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2407 Harmon Road, Silver Spring, MD 20902 Mildred M. Carlson/Wife f Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö March 21, permit. Page Department of Important: If any injury or once. Alexandria, Virginia Metropolitan Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. Part 1. Inter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Immediate Cause (Final disease or condition resulting in death) **Physician** -ARDIOGENIC /Medical Examiner RITICAL Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Completed by Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Anpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 22 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. 27. Manner of Death 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D 🄁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 66771 wno completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park, MD 20912 Ang Galena-Santiago, MD 31. Date filed (Month, Day, Year) 32. gistrar's Signature State MAR 2 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

the Maryland

2 should be filed within 72 hours after death with

law requires that the death certificate be executed

Hospital or Attending Physician:

Division of Vital Records. P.O. Box 68760.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year 11:05 PM 2008 /Medical Facility Name (If not institution, 4c. County of Dea Examiner saltimore TIMARE (ente If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Sex 1ÅM 2□F 7. Age (In yrs. last birthday) **Funeral** 578-46-310.7 72 April 10, 1935 Washington, D.C Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other tranmatic event, the Medical Examiner must be notified at any or other tranmatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Ceci1 Director Maryland 1 Yes 2 No Perry Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Building 5H U.S.A. 21902 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 X Yes 2 No 1966 − 1972

If Yes, Give 1972

Year or Dates: 1972 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 ☑ Widowed 4 ☐ Divorced 1972 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) United States Airforce College (1-4or 5+) Staff Sgt./ Communications Specialist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alphonso B. Dean, Sr. ပ္ Nancy A. Dowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 Roland Drive, Santa Cruz, CA 95062 19a. Informant's Name/Relationship (Type. Print) Thomas S. Dean, Jr.-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/14/2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Constance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician monury disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) I Yes 2 □ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and this 29d. Date signed (Month, Day, Year)

State Registrar person who completed cause of death (Item 23a) (Type, Print)

Physician /Medical Examiner Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Be Completed by Funeral Director DUNHAM RUSSELL D Baltimore, Maryland 21215-0036 ဂ္ Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The within 24 hours after deah. To the Funeral Director, After this certificate completely filled in by the funeral director, pag

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25. Was case refer examiner?	red to medica		italı		/				e of Death	h (Check only	one)					
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DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 17. George С. DuLaney 9:42 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis LaPlata Center Charles LaPlata 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) February 3, 1928 Birthplace (State or Foreign Country) **Funeral** Days Months XXIM 2 IF 80 577-32-7181 Director Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XXVo Director Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? ns 23a o 4038 Lyons Street 20748 LISA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 10/6 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status XX Yes 2 No 1946— If Yes, Give Year or Dates: 1952 Black, White, etc. 1 ☐ Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White þ Specify: 3 Widowed 4 Divorced er than "natura the Medical E Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer U.S. Park Police 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barrett DuLaney Mary Schlegel George 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas DuLanev / Son 36886 Kimberly Court Mechanicsville, Maryland 20659 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
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Important: If ite
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 03/25/2008 Resurrection Cemetery 4 □ Donation 5 □ Other (Specify) Clinton, Maryland Funeral Service Licensee 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home P.A. al 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Farti. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DUANCIUD **Physician** TISCOSELERO SIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner -SURAAGU ANCIER. Some of the control of the course of the cou Due to (or as a consequence of): Examine The law requires that the death certificate be executed ANCIEN that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician by Physician/Medical as the IF FEMALE: asn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy ō Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 TYes No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was and autopsy performed? Yes 212 No has page 2 this certificate Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: AND Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XX No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 XXNatural 5 Pending investigation 1 🗌 Yes within 24 hours after death To the Funeral Director: the 1 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined ACCUMENTAGE CONTINUES AND ACCUMENTAGE CONTINUES AND ACCUMENTAGE AND ACCUMENTAG 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number

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State Registrar te filed (Month, Day, Year)
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WALDORY MC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Marylan		artment of H		-	giene Reg. No.	008	11156
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Fune: Direct		5. Social Security Number 6. S 236-64-8086	Sex 7. Age (In yrs.	Yrs.	Months Days	Hours Mi		ıy, Year)	Co	thplace (State or Foreign buntry) Virginia
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T VICA Tysician: Tis certific director,	To B	Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	t 3 DOA Oth	or	Home 5 Res		☐Other (Spe	ocify)
On OI ding Phy h. After this funeral d			28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe	how injury	occurred	
VISIO Attendi er death. rector: A	Cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	00(1)			
DIVISION I or Attending after death. Director: Afte	ertification:	4 Homicide determined		ome, farm, str y)	eet, factory, office		City or To	Street and wn, State)	Number or H	ural Route Number,
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funear Director: After this certifics completely filled in by the funeral director;	C)	nysicien: To the best of my kno	wiedge, deati	n occurred at the tir	ne, date and pla	ice, and due to the	cause(s) a	nd manner as	s stated.
Me Hoo	edical	(Check only one) Medical Exer	miner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death oc	ccurred at the time,	date and p	place, and due	e to the cause(s)
To th withir To th	M	29b. Signature and till of certifier			29c. Licens	e number		29d. Date	signed (Mont	th, Day, Year)
		A Atro.	one		Doo	56965		MARC	4 25.	2008
£ 13 1		30. Name and address of person who	completed cause of death (Item	п 23а) (Туре,	Print)					
3H1+1	C1 .	31. Date filed (Month, Day, Year)	251 E. Anti	oten S	treet Hag	erstown	, MO 21.	140		
Reg	State istrar		2000	M A	See all	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>008</u> **Physician** Month GRAYSON DeGRANGE. JR. March 20, 1:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** College View Center Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F 72 218-30-9654 JAN. 26, 1936 **Director** Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Frederick 1 X Yes 2 No Director Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 United States 800 Motter Funeral Ave. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 M Yes 2 □ No
If Yes, Give
Year or Dates:1961-65 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: White 3 ☐ Widowed 4 💆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Labor 12 construction marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F Be 1 and 2 should be Grayson L. DeGrange, Sr. 2 Catherine Beard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau 4334 Araby Church Rd. / Frederick, MD Jean Whipp / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem.Garden 103/22/2008 4 ☐ Donation 5 ☐ Other (Specify) Frederick. Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21.702 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock to heart failure. List only one cause on each line.

Immediat Tause (Final disease x condition resulting in death)

a. Due (or as a consequence of the condition of Approximate Interval Between Onset and Death Physician /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760 attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 Unknown ed by the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign 1 be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 Yes 2 No
27. Manner of Death
1 Natural 5 Hospital: Other: Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

2+1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

05 6

32. Registrans Signature

shah

MAR 2 5

29c. License number

DO060417

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State o	f Maryla		artmen rtificat				Mental Hyg	jiene	0.8	D	58
	DI .		1. Decedent's Name (First, Middle	, Last)					•		2. Date of Dea	th	V	3. Time of	Death
	Physic /Medi		EUGENE	ROBE	RT	DOEF	RFL	110	SEP	2	Month 03	ZZ	2008	215	5 м
	Exami		4a. Facility Name (If not institution						Location of			4c. Coun	ty of Death		
			WASHINGTON ADVE		OSPITA	2			LAP,				TOOM	eny	
	Funeral		5. Social Security Number 052-38-8942	6. Sex 12☑ M 2☐ F		s. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day April 5,	Year)	9. Birthp	lace (State o	r Foreign
	Director		Usual Residence of Decedent	12.11	60	Yrs.					April 5,	1947	New	York	
	and wo		10a. State 10b. County		10c. 0	City, Town or Lo	cation						1	0d. Inside Ci	tv Limits
	Maryłan f ehow	ō	Manual and Manua			C	Conto	~						1 🗌 Yes	-
	r 28a	rec	Maryland Montgo	Smery		Silver	10f. Zip				1	0g. Citizen of	What Coun	itry?	
	h with	D E	13122 Colling	wood Ter	race				20	0904			USA	•	
	deat	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in	U.S. 13.	Nas Deced	lent of Hi			pecify Yes or No- Rican, etc.)		ce - Americ	an Indian,	
9	or lite	교	1 [™] Never Married 2 Marri	ed 1 Yes If Yes, Giv	2 🔼 No	1	1 Yes, spec 1 □ Yes 2				Hican, etc.)		ack, White, Wh	etc. ite	
003	ural',	d by	3 Widowed 4 Divorced	Year or D	ates:		10 163 4	2121110	эреспу.			Speci	ity:		
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f ehow fre Madical Exemirer must be notified at	Completed	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation Juring most	t of work	ing	16b. Kind of 8	Business/Ind	dustry	
72	than the	E G	Elementary/Secondary (0-12)	College (1	I-4or 5+)		None	ie retired,)			N/A			
CA	Hygie ther int.		17. Father's Name (First, Middle, L				NOTIE		18 Mothe	r's Nam	e (First, Middle, I		.mo.)		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene Item 27 is marked other than "natural", or Items 23a or 28a-1 ehov other traumatic event, the Medical Examinar must be notified at	To Be	Eugene Walter		er						largaret		ine)		
Ž	Shoul mark mati	F	19a. Informant's Name/Relationsh			19b. Mailir	n Address	(Street a			ral Route Number		State Zin	Code	
	1 and 2 Health a lem 27 is		Richard M. Doer:		rother						race, Si				20904
Baltimore,	ges 1 an it of Heal if item 2 or other		20a. Method of Disposition	. = -		Place of Dispo	sition (Nan	ne of	9)			20c. Location	- City or To	wn, State	
Ē	Pages nent of ant: If it		1 ☑ Burial 2 ☐ Cremation 1 ☑ Burial 2 ☐ Cremation 1 ☐ Other (Sp		State Ga	te of H	eaven	Cen	ietery	у МА	RCH 28, 2008	Silver	Spri	ng. Ma	arvla
at	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	.icensee			. Name an							3,	
_	49 E E 9		Alama a	las C.	-	50	oncis Uni	vers	ity E	ins Blvd	Funeral , W, Sil	ноше л ver Sp	ring,	MD 20	901
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cannot one cause on e	auced the dea	ath. Do not ent	er the mode	of dying	g, such as	cardiac	or respiratory arre	est,		Approximate Interval Bety	een
	Physician		Immediate Cause (Final disease or condition	ATHE	ROSC	LEROTI	c C	tRO.	OVA.	scu	UR D	ISEMS	E	Onset and D)eath
	/Medical Examiner		resulting in death)		or as a conse										
		<u>.</u>	Sequentially list conditions,	b. Oua to /	or as a conse	and and affi	1000							-	
	ted nsit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	300101	OF 38 & SUI 180	querio-sty.									
	al-tra	xar	that initiated events resulting in death) Last	c	or as a conse	quence of):									
8760,	death certificate be executed e attending physicien and ad for use as the burial-transit	dicai E													
68	ificate g phy as the	edic	72 100	0.					-						
Вох	leath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			_					23d. Da	ate of delive	rv	
a.	the atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregna	irth 2□Fei ant at time of		Ectopic pre Other (spe							•	'еаг
P.O.	ac ac	Physician/Me	9 Unknown	9□ Unkno											
		þ	Part II. Other significant condition	18 contributing to de	ath but not re	sulting in the ur	derlying ca	luse give	n in Part I.		23e. Did tob	acco use con	tribute to th	e cause of de	eath?
ord	law requires as been sign 2 should be	ted									1 🗆 Ye	s 2 No	3 Proba	ably 4 U	Inknown
ec	has by ge 2 sh	Completed									24a. Was ar autops	n 24b.	Were autop	sy findings a	available
	pa pa	Co									perform	ned?	death?	211No	
Vita	ysician: This contificate	Be	25. Was case referred to medical examiner?	l Linearitati						of Deat	h (Check only on	9)			
	dil dil	5	1 Yes 2 No 27. Manner of Death			ER/Outpatren			4 🗆 1901		me 5 Reside)	
LO.	ding h. After fune	tion	1 Alatural 5 Pending		h, Day Year)	28b. Time of Injury	M	Bc. Injury Work	at ? ′es 2.⊟N		28d. Describe ho	w injury occu	rred		
Division of	l or Attsnding Ph after death. Director: After th i in by the funeral	fica	3 ☐ Suicide 6 ☐ Could no	ot be	of Injury - At I	nome, farm, stre			93 Z [_]	-	28f. Location (Sti	reet and Num	her or Pural	Pouto Numb	har
<u>S</u>	after after t Direct d in by	Certification;	4 Homicide determin	buildir	ng, etc. (Spec	ify)	, ot, 140tory,	Onice			City or Town		Der or Aurar	HOUSE NUMBE	let,
	Hospital 24 hours 6 Funerat I		29a. Certifier 1 Certifying	Physician: To the	best of my kn	owledge, death	occurred a	it the time	e, date and	d place.	and due to the ca	use(s) and m	anner as sta	ated	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical E	xaminer: On the ba and mann	isis of ex a min	ation and/or inv	estigation,	in my op	inion, deat	h occurr	ed at the time, da	ate and place,	and due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c.	License	number		25	d. Date signe	ed (Month, D	Day, Year)	
7			1900	mo					603	19		03	, 22	, 200	28
			30. Name and address of person w			m 23a) (Type, I	Print)	7,	A1 19		TAN	MA A	ARI.	m	
	Sta	e	DARCIE HAM 31. Date filed (Month, Day, Year)		760 egistrar's Sign	ature	140	16	NUE	/	ITERU	VVVT I	111-K	שווי	
	Registr		MAR 2 4 2		was d	k Soo	The same				TAKO				

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

Registrar

31. Date filed (Month, Day, Year)

PRAYEEN BOLDRUM, NO, 1967JPLIVE, FREDENCE, ND-21703.

32. Registrado Signature

2008

20062223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Ma	ryland / Depa Ce	rtificate of		wieniai ny	Reg. No. ?	108	11160
دود	Physici	an	Decedent's Name (First, Middle, La	,				2. Date of De Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, giv	ce Ehrlich		4h City Town o	r Location of Deatl	March	19 4c Goun	2008 ty of Death	6:10 a M
}	Examin	er	Brighton Garden				thesda	'	10.00011	Montgo	merv
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		rth		lace (State or Foreign
Sa.	Director		579-60-9971	□ M 2 X F	102 Yrs.	Months Days	Hours Min.	(Month, Da	20, 1905	Coun	Russia
	land ow It		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
	Mary a-f she fied a	tor	Maryland Montgor	nerv			Rockville				1. ■Yes 2□No
	or 28%	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	ath wi		10401 Grosvenor				20852			U.S.A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 N If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 1 No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	Spec	ace - Americ ack, White, ify:	
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12	illed w Hygier ther ti	S	12 17. Father's Name (First, Middle, Last		Adve	rtising Cop	ywriter 18. Mother's Nan	ne (First Middle		Adverti	sing
Maryland	ld be ental ked o	To Be	Samuel Solow					nna Maise		imoj	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailii	ng Address (Street	and Number or Ru	ıral Route Numb	er, City or Tow	n, State, Zip	Code)
	and 2 ealth a n 27 is		Richard Ehrlich	Son		4 Jasmine D		ville, Ma	ryland 20	853	
Baltimore,	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of Dispo cemetery, cre Parklawn Me Menorah	sition (Name of natory or other plac emorial Par Gardens	k & 03/	Date 21/2008	20c. Location Rockvil		•
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licer	Luder	$\mathcal{S}(a)$ 1	2. Name and Addre ines-Rinald L800 New Ha	i Funeral I mpshire Ave	enue, Sil	ver Sprin	g, Mary	land 20904
n.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. Do not ent	er the mode of dyir	ig, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		rdial Infarc						Onset and Death
	/Medical Examiner		resulting in death,		consequence of):						
E		Je.	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	D.	consequence of:	raliure					·
	scuted nd transit	Examiner	Cause (Disease or injury that initiated events	·	tension						
90,	be execian a		resulting in death) Last		consequence of):						
68760,	tificate be executed g physician and as the burial-transit	edical		d. Anemi:	a			<u> </u>			
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		1			23d. D	ate of delive	ry
.O. Box	The law requires that the death cer Ite has been signed by the attendir oage 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 图 No 9 □ Unknown	1 □Live birth 2 4 □Pregnant at t 9 □ Unknown		Ectopic pregnancy Other <i>(specify)</i>			N	lonth	Day Year
Δ.	that the ed by detacl		Part II. Other significant conditions	ontributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
rds	w requires that the di been signed by the should be detached	od by						1 🗆	Yes 2 No	3 Prob	ably 4 □Unknown
Vital Records,	has bee	Completed						24a. Was		. Were auto	psy findings available inpletion of cause of
<u>~</u>		Som						perfo	ormed?	death? 1 ☐ Yes	
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ō	Phys r this eral dir	٩ ا	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	/ 28b. Time o		4 E5 Nursing n	ome 5 Resi	dence 6 00)
on	ndlng tth. r: Afte e fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	f 28c. Injur Wor M 1 □	k? Yes 2 □ No				
Division or	al or Atte after des 1 Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (City or To	Street and Nurr wn, State)	ber or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Medical C	29a. Certifier 1 ★ Certifying Ph (Check only one) 2 ★ Medical Exar	ysician: To the best of niner: On the basis of and manner stat	examination and/or in	occurred at the till vestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and r date and place	nanner as st	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of pertifier	~		29c. Licens	e number		29d. Date sign	ed (Month, i	Day, Year)
)	12) that	-M.D		D	30132		March	20, 20	800
			30. Name and address of person who				ito 161 "	ooly 11	Marral 1	20050	
1	Sta	e	M. Rita Ghosh, M. 31. Date filed (Month, Day, Year)	.D., P.C., 14	's Signature		1ce 161, K	ockville,	maryland	20850	
	Registr		MAR 2 4 200	400	H. Com	del					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March OSCAR WAYNE FOWLER 2008 6:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 401 Delaware Road Frederick Frederick 8. Date of Birth (Month, Day, Year)

Jan. 23, 1915 Pennsylvania 5. Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 1√ M 2□ F Hours 210-05-1353 93 Director Usual Residence of Decedent la or 28a-f show I be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∏Yes 2∏No Director Mary1and Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Delaware Road "natural", or items 23a 21701 Funeral USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. þ Specify: 3X Widowed 4 ☐ Divorced White Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed witnent of Health and Mental Hygier tant; If item 27 is marked other the jury or other traumatic event, the Sales Representative Dairy Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wayne Fowler Blanche Casey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any Injury or other trau Patricia Spann / Daughter 401 Delaware Road, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3/28/08 5 Other (Specify) Monongahela Cemetery 4 ☐ Donation Monongahela, PA 21. Signiture of Pineral Service Licensee RÓBERT E. DAILEY & SON FUNERAL HOMES, P.A. NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician Ceronar years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the carrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tra Due to (or as a consequence of): physician Physician/Medical the as ISe IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown , page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ⊟ Yes 2 🗹 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours after death To the Funeral Director: Hospital completely

Baltimore, Maryland 21215-0036

20

State Registrar

29a. Certifier

one)

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oren WS

Gen

D32073

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

610

Brunswick

31. Date filed (Month, Day, Year) 32. Registrat's Signature MAR 2 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20, 2008 11:50 AM Yarah /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Cour Howity big Genera 010 If Under 24 Hrs. Age (In yrs. last Social Security Number **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 **x** M 2 □ F Months Days Hours Min Director 255-54-3089 71 August 12, 1936 Georgia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits r 28a-f show notified at 1 ☐Yes 2 X No Director Maryland Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 1728 Cattail Meadows Drive 21797 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Armed Folces: 1 X Yes 2 No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Orthopaedic Surgeon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H :ant: If item 27 is marked oth Be William Jennings Bryan Fleming Daisy Elizabeth Bowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trains Elizabeth M. Fleming - Wife 1728 Cattail Meadows Drive, Woodbine, Maryland 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Crematory 03/28/2008 Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 21. Signature of Funeral Service Licensee th caused the deathse on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of the complete complete the complete compl not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of Library that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ page 2 should be Mascar 1 🗀 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Pancretio Cance 2 No Yes . Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 20+1

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

egistrar's Signature

eom

24

31. Date filed (Month, Day, Year)

MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Vear $7:10 P^{M}$ DAVID CROMWELL FOWLER 2008 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE 8. Date of Birth (Month, Day, Year) MAY 4 1 9 1 4 6. Sex If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) WV Months 1**⊠**M 2□F 232-10-7855 93 Director Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits show an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at WV BROOKE WELLSBURG Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? RT. 1 26070 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 N If Yes, Give 7 Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than filed withii Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN ALLEGHENY POWER traumatic event, the 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h FRED FOWLER RUTH LENTZ ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 0838 Department of Health a Important; If item 27 is any injury or other trau SANDY GILLIAM / DAUGHTER 22311 OLD HUNDRED RD., BARNESVILLE, MĎ 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) FRANKLIN CEMETERY WELLSBURG, 3/28/08 21. Signature of Fun-22. Name and Address of Facility HILTON FUNERAL HOME BOX 86, BARNESVILLE P.O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirativy arrest shock, or heart failure. List only one cause on each line. Approximate al Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ~ on Due to (or as a consequence of) Examiner requires that the death certificate be executed aftending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 □ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? page 2 1∏ Yes 25. Was case referred to medical exampler? Be 26. Place of Death (Check only one Other: 4 Nursing Home Hospital: Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 5 ☐ Residence 6 ☐ Other (Specify) Man of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending s after de. ral Director: Atte Natu al 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No cident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 24 hours a Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

6

Registrar

DHMH 17 Rev 1/2001

State

9901 MEDICAL CENTER DR., ROCKVILLE,

MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

MD

32. Registra s Signature

WILLIAM DOOLEY,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 03/14/ 2008 Year **Physician** 04:35 a M Elizabeth Gonzalez Ziomara /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital | If Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 03/114/2008 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number **Funeral** 1□ M 2√F Director none Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Md. Montgomery Montgomery Village 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 20880 U. S. A. 18116 Copps Hill Place or items 23e Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. fited within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: Salvadoran à 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none is 1 and 2 should be filed voil Health and Mental Hygie item 27 is marked other 27 is 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sandra Gonzalez Unknown ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18116 Copps Hill Place Montgomery Village 86. Sandra E. Gonzalez (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate permit, Pages 1 Department of H-Important: If ital any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/17/2008 Adelphi, Md. George Washington `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N.W. Washington, D.C. 20010 21. Signature of Funeral Service Licenson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) REMATURITY **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit HORIOAMNIONIFIS that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetaf death 3 ☐Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛣 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2€ No 1 🗌 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Npatient 2 ☐ ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D38315 gromas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE, ROCKVILLE MD 20850 DAVID ZUCKERMAN 31. Date filed (Month, Day, Year) State MAR 1 7 2008

DHMH 17 Rev 1/2001

Registrar

State Registrar NOVACIC

DANICA

MAR 1 7 2008

225. Greene St.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ۶ã 2008 8:30 A^{M} March John Phillip Grace /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerford Place Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Year) Months 1X M 2 □ F Director 215 09 1701 91 Aug 22, 1916 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 □Yes 2 X No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
int: If Item 27 Is marked other than "natural", or items 23a or 21043 8046 Old Montgomery Rd United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 25€ No Specify. þ Specify: 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown Scrap Yard Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Katherine Eichelman George Grace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mae Sheehan/Daughter 8038 Old Montgomery Rd Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any injury or o once. Burial 2 ☐Cremation 3 ☐Removal from State Meadowridge Mem. Pk. 3-27-2008 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-trai resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending properties for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s nas autopsy performed? Yes 2 No 1 | Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2K No 1 🔲 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 il or Attending Fafter death. 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) ind manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 24, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 301 Snowden Columbia 8600

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

MAR 2 5 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 19 2008 ам Richard Edward Galicki March 5:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1137 Deer Park Road Westminster Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Date of Birth (Month, Day, Year) Hours 1**½** M 2 □ F Months Days Director 216-66-8490 54 Oct 02 1953 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 21157 1137 Deer Park Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Division General Manager Vulcan-Hart Corp 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Victor Galicki Clara Bullen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Galicki/wife 1137 Deer Park Road Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Cremation, Inc 03/19/2008 Hampstead, MD 4 □ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 caused the death. Do not enter the mode of dying, such as carpiac or respiratory arrest, 23a Part1 Enter the disease, or complications that shock, or beart failure. List only one cause on Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) [ע **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of

Box 68760, Records, Division or Vital To the Hospital or Attending Physician: this After within 24 hours after user... At To the Funeral Director. Aft

WI 20

State Registrar

Certification:

Medical

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

(Check one) 29b. Signatu

4 ☐ Homicide

who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

2008

5 ☐ Pending investigation

6 Could not be

and title of certifier

determined

ater Street Wishiuster, 4) 21157

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Year IRVIN D. GORDY Meurch 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lanham P.G. Doctor's Community Hospital 8. Date of Birth (Month, Day, Year) 5-5-30 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) **Funeral** Days Months Hours Min. 1**X** M 2□ F 77 Delaware Director 222-14-7465 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at P.G. Mitchellville 1 XYes 2 No MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 U.S.A. 20721 11408 Waesche Drive Funeral ural", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 □X es 2 □ No 7/1/49
If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Black Completed by 3 Widowed Woivorced Year or Dates: 12/9/52 Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Teacher College PhD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estella Gordy Delton Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

College P

Park Dr. #1820 Md. 20740 ပ 19a. Informant's Name/Relationship (Type. Print) Park Irvin D. Gordy, Jr./Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important; If it any injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 3/28/08 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funeral Service Licensee 22. Hackett si Fail Tuneral Chapel, Inc. 814 Upshur Street, N.W. W. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNCESTIVE Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy for Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) I ☐ Yes 2 ☐ No detached 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 1 Inpatient 3□ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier ca and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 54675 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good huck Rd. harham, mD. 20706 MD. 31. Date filed (Month, Day, Year) . Registrar's Signature State MAR 2 4 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of M Registrar	-	artment of Health and rtificate of Death	Mental Hygie Reg.	_/HIIX 1 b 4
	t &	7	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physic		Louise	1 G	ines	Month 03	Day Year 22 08 0125 M
Vanis	/Medi Examiı		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat		4c. County of Death
	LAGIIII	ICI	Pannaun Agund Magan	Both	SAISHING	/	Niconico
	Funeral			ge (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		218-20-4813 10M 2) 10 M 2) 15 F	85 Yrs.	Months Days Hours Min.	(Month, Day, Ye	ear) Country
100	70		Usual Residence of Decedent			10 11 11	23 yelware
	ylan how at		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Mar a-f sl	핝	De Sussex	Lau	rel		1 Yes 2 □ No
	r 28	Director	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Country?
	h wit		32103 S. Summer	Court	19956-348	73	1150
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show lical Examiner must be notified at	Funeral	11 Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
9	after or Ne nine		1 Never Married 2 Married 1 Yes 2	No	If Yes, specify Cuban, Mexican, Puèr	o Hican, etc.)	Black, White, etc.
8	ral",	b	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		Specify: Dlack
215-0036	72 hc natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during most of wor	16l	b. Kind of Business/Industry
21	thin an "l	ğ	Elementary/Secondary (0-12) College (1-4or	life. I	DO NOT use retired)	\ming	26 01
21	d wi	등	200		DUPCTUISON		hicken Plant
pu	al Hy loth vent	Be (17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Mai	iden Surname)
Maryland	uld b Vent Vent rrked rric e	To I	George A 1	leshield	s Mar	tha :	J. Burris
ar)	and I	ľ	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number or Ru	ıral Route Number, C	ity or Town, State, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa once.		Vanessa Moore (Nieco	2) 3210	3 S. Summer Cour	+ Laurel	Delaware 19956
ē	item oth		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Date 200	c. Location - City or Town, State
Ę	Page lent c nt: If ny or		1 ☐ Burial 2 Cremation 3 ☐ Removal from State	(me made	1 of D.L. 3-2	24-2008 (V	Pilmer Oil
Baltimore,	mit. artm ortal inju	ll à	21 Signature of Fueral Service Licensee /)	22	A. Name and Address of Facility	917/1/1	Elmar Delapare Subella Street
ä	permi Depar Impor any ir once,		June Fake	R	ennie Smith F. H.	Silvia	on Maryland 21801
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li				
		25 1	shock, or heart failure. List only one cause on each li immediate Cause (Final	ne.	(Ce		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	UDUM D	I Halt walls		
	Examiner		Due to (or as	a consequence of):	HEART FAIL	RI	
65		<u>_</u>	Sequentially list conditions,	a consequence of):	navia ritu	415	
	ted isit	Ę	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence or).			
	and and t-trar	Examiner	that initiated events	a consequence of):			
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68760,	cate be executed physician and the burial-transit	dical	d				
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o.	the a	/sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	t time of death 5L	Other (specify)		Morial Buy rous
P.0	d by letac	Ph	Part II. Other significant conditions contributing to death b	ut not sociation in the co	adoshina saves sives is Book!	ODA Didashaa	
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<u>it</u> a	ilan; ertific ctor,	Be (25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
or Vital Records,	Physician: The law requires that the death certificate this certificate has been signed by the attending ral director, page 2 should be detached for use as	To	1 Yes 2 No Hospital: 1 Inpatie	ent 2 ER/Outpatien	t 3 DOA Other: 4 Nursing H	ome 5 Residence	e 6 ☐Other (Specify)
0	ding Ph .r After th funeral		27. Manner of Death 28a. Date of Inju 1 ☑ Natural 5 ☐ Pending (Month, Da	ry 28b. Time of y Year) Injury	28c. Injury at Work?	28d. Describe how i	
Division	ath. ath. or: Af	atio	2 Accident investigation	y roary injury	M 1 ☐ Yes 2 ☐ No		
Ϋ́	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined 28ePlace of injusted	ury - At home, farm, stre c. (Specify)	eet, factory, office	28f. Location (Stree	t and Number or Rural Route Number,
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	ospii hour unera ly fille		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, death	occurred at the time, date and place	, and due to the caus	e(s) and manner as stated.
	n 24 n 24 ne Fi cietel	Medical	(Check only one) 2 ☐ Medical Examiner: On the basis of and manner sta	i examination and/or invated.	resugation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
	Vithi Somp	ž	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
	-7		► (SHIQI _ MUD		D63433		3/22/10
7	Jan		30. Name and address of person who completed cause of d	eath (Item 23a) (Type. F			1-0/08
	Pa		NGMAL DOSMI IOL M	ILFORD CT	1 #504B, MU	21804	
	Sta	te	31. Date filed (Month, Day, Year) 32 Registro	ar's Signature	1)		•
	Registr		MAR 2 4 2008	· A A	Section 1		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1-	For State Registrar			State o	f Maryla		•	ent of F				Reg. No.	008	117
ician dical niner	На	zel V.	ne (First, Middle <u>Herrir</u> (If not institution	ng	eet and nu	mber)		4b. (City, Town, o	r Location	of Death	2. Date of De Month March	Day 18	Year 200 County of De	8 1:50 A
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Director	Mar 10e.	yland Street and Nu	Frede	rick		Fr	ederio		. Zip Code				10g. Citi	zen of What (1 Yes 2 X
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Completed by Ph	Parti	I. Other signi	Hype		buting to do		resulting in t	he underlyi	ng cause give	en in Part I.		23e. Did to	Yes 2	No 3 ☐ F	to the cause of death? Probably 4 Unknow autopsy findings availa completion of cause
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a)	- A		No	-		npatient 2 of Injury th, Day Year	ER/Outp	ne of	28c. Injun Work	/ at	:	me 5 Resid 28d. Describe h			ecify)
To Be	27. M	Natural	5 Pendin investig	gation	[1416.11										
Certification; To Be	1 27. M 1 2 3 4	Natural Accident Suicide Homicide	5 Pendin investiç 6 Could a determ	gation not be nined	28e. Place buildi	of Injury - Ang, etc. (Spe	ecify)	n, street, fa				City or Tou	vn, State)		Rural Route Number,
Certification; To Be	27. M 1 22 3 4 29a.	Anner of Deat Natural Accident Suicide Homicide Certifier	5 Pendin investig 6 Could a determ 1 Certifyin 2 Medical	gation not be nined ng Physici Examiner	28e. Place buildi ian: To the	ng, etc. (Spe	crify)	n, street, fa	red at the tim tion, in my op	ne, date an pinion, deal	d place.	City or Tow and due to the ed at the time,	vn, State) cause(s) date and	and manner a place, and du	as stated. as to the cause(s)
To Be	27. M 1 23 3 4 29a.	Anner of Deal Natural Accident Suicide Homicide Certifier (Check only one)	5 Pendin investig 6 Could a determ	gation not be nined	28e. Place buildi	best of my lasis of examiner stated.	nowledge, of the last of the l	death occur or investiga	rred at the tim tion, in my op 29c. License	ne, date an pinion, deal e number	d place, a	City or Tow and due to the ed at the time,	cause(s) date and 29d. Date	and manner a place, and du signed (Mor	as stated. se to the cause(s)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar w

Year)

MAR 0 6 2008

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Jegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Ma	aryland /		artment of F rtificate of I		and Me	, ,	_	0050	
W 8 W		Registrar 1. Decedent's Name (First, Middle, Last)				timodio or i	Death		2. Date of Dea		2008	3. Time of Death
Physicia /Medic		MILDRED F	ELIZABETH	HARL	EΥ				Month March	23, 2	2008 ^{Year}	11:45 P M
Examin		4a. Facility Name (If not institution, give s	_		_	4b. City, Town, o		of Death			County of Death	
	.:	N M S , Health (5. Social Security Number 6. Sex	Center	e (In yrs. last b	irthday)	Hagerst If Under 1 Year	own If Under:	24 Hrs 6	3. Date of Birth		ashingto	
Funeral Director		214-20-4850	M 2XF	86	Yrs.	Months Days	Hours	Min.	(Month, Day AUG • 18	, Year)	Cour	place (State or Foreign htry) land
land ow ft		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	ocation					1	0d. Inside City Limits
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th the	Funeral Director	10e. Street and Number				10f. Zip Code				I0g. Citize	en of What Cour	ntry?
23a c	ra L	17031 Oakleigh	Way			21740				Unit	ed Stat	tes
er dez tems	nne		Was Decedent I Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig	gin? (Spec), Puerto R	ify Yes or No- ican, etc.)	14	4. Race - Americ Black, White,	
San sa	ρ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 □ Yes 2 🛣 i If Yes, Give Year or Dates:	40		1 ☐ Yes 2X No	Specify:			5	Specify: W	hite
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d Z1Z15- filed within 72 Hygiene. other than "nat ent, the Medic	S	17. Father's Name (First, Middle, Last)			поше	emaker	18 Motho	r's Nama /	First, Middle,		own home	
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ire, Maryla		Warren T. Harley ,	Jr./ So			l Oakleig						
0 0		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Re	amoual from State	20b. Place o	of Dispo	sition (Name of natory or other place	e)	Da	te	20c. Loca	ation - City or To	wn, State
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baltimo permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service License	5	- 5		2. Name and Addres						1.700
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Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final			4	s. C	y, 30011 a3	cardiac or	respiratory arr	g 4		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as	∾ all a consequence	of):	11 Ca-	uno	MA	01	L-01	ng	
Examiner		Communication that the same and the		onic	0	struct	(10	ri	~	pisc	asi	
D #	in e	Se grentially list commediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):	11 Car bstruct Adria	ı	F	ha: ha	1	. \	
ecute and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as	consequence		Adres	<u> </u>	- 1	71 1 40	-11		
ificate be executed physician and as the burial-transit	四日		Due to (or as a	z consequence	01).							
ificate g phys	edical	d.										
box of leath certification attending for use as	N N	zob. Was decedent pregnant	c. If yes, outcome 1 □Live birth		h 2F	Testopio prognanci				23	d. Date of delive	ery
e deal he att	Physician/M	in the past 12 months?	4☐Pregnant at 9☐Unknown			Ectopic pregnancy Other (specify)					Month	Day Year
hat the d by t letach	시	9 ☐ Unknown Part II. Other significant conditions cont		it not requiting i	n the	deshing one	on in Don't		00 - Did - 1			
	g	Tarti. Other signmount conditions con	induling to death bu	it not resulting i	ii tile ui	idenying cause give	ai iii Faiti.				e contribute to th No 3 ☐ Prob	e cause of death?
law requires that seem signer 2 should be o	Completed								24a. Was a			
The lar e has	ᇎ				-				autops perfori	у	prior to cor death?	osy findings available npletion of cause of
an:]	Š P	25. Was case referred to medical			-		26 Place	of Death (│ 1□ Yes : Check only on	2/2/No	1 ☐ Yes	2□ No
nysici nis cel direc	0	examiner? 1 ☐ Yes 2 ☑ No Ho	ospital:	nt 2 ER/O	utpatien	t 3 DOA Othe	ar.	_			□Other (Specify	·)
Ing Phy	ä	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Injury Work			d. Describe ho			<u> </u>
ttendi leath. tor: A	Cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00 - Di - / / /				Yes 2□N					
al or A affect of I Direct of in by	Certification:	4 ☐ Homicide determined	28e. Place of inju building, etc		arm, stre	эет, тастогу, описе		28	t. Location (St City or Town	reet and i n, State)	Number or Rura	l Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical C	29a. Certifier (Check only one) (Check only one) (Check only one)	er: On the basis of	examination as	e, death	n occurred at the time	ne, date and pinion, deat	d place, an	d due to the c	ause(s) a	nd manner as st	ated
thin 2 the land the l	Med	one) 29b. Signature and title of certifier	and manner sta	ted.		29c. License						
F. M. F. S		L.C. w	whenh			200		56	2	2/	signed (Month, L	Jay, rear)
5	-	30. Name and address of person who con	npleted cause of de	ath (Item 23a)	(Type I			10		0 5	-11-	
5						0 (200)	71	HOC	ma	5	17/1	

31. Date filed (Month, Day, Year) 32. Registra Signature State MAR 2 5 2008 Registrar **ORIGINAL**

		Please 1			Indelible Ink			•	
		1 - For State Registrar	Otato of Mic	,	Certificate of		, ,	. No. 2008	8 11173
Physicia	an	Decedent's Name (First, Middle, Las.	•	_			Date of Death Month	Day Year	3. Time of Death
/Medic		Faye 4a. Facility Name (If not institution, give	-	I I	Hayhoe 4b. City, Town, o	or Location of Death	March	23 2008 4c. County of Dea	
Examin	er	Frederick Memori		al	Freder			Frederic	ck
Funeral		Social Security Number 6. Security Number	7. Age	e (In yrs. last birtf	hday) If Under 1 Year		8. Date of Birth (Month, Day, Y	9. Bir	thplace (State or Foreign ountry)
Director		577-36-2824 Usual Residence of Decedent	JWI ZIAI	78 ^Y	rs.		March 22		shington, DC
/land ow at		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
a-f sh	ctor	Maryland Montgomer	y	Gaither	sburg				1 □Yes 2 No
ith the	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What Co	ountry?
s 23a		12804 Meadow View			20878	"!- O-! !-0 (O-		ISA 14. Race - Ame	vices Indias
ter de Item	Funeral	11. Marital Status 1 ☐ Never Married 2 X Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N		13. Was Decedent of F If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, Whit	
ours al al', ol Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: Wi	nite
72 ho "natu dical	etec	15. Decedent's Ed (Specify only highest grad		1	Decedent's Usual Occup (Give kind of work done	during most of work	king 16	6b. Kind of Business	/Industry
within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	`life. DO NOT use retire nemaker	a)		wn home	
2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "ratural", or Items 23a or 28a-f show is marked other than "ratural", or Items 20a or 28a-f show aumatic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)		11011	iciiakei	18. Mother's Name	e (First, Middle, Ma		
Menta	To E	Alonzo Perkins Par	rish			Margaret	Isabel R	outten	
2 sho		19a, Informant's Name/Relationship (7	ype. Print)		Mailing Address (Street				
1 and Health em 27		Susan M. Thompson, 20a. Method of Disposition	daughter	20b. Place of	Disposition (Name of	_ i		rovia, Ma	ryland 21770 Town. State
ages ent of it: If It		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1	y, crematory or other pla incoln Cemet	i i	/2009 12		Manual and
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merthal Hygiene. Department of Health and Merthal Hygiene. Interportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of uneral Service Licen		POIL LI	22. Name and Addre	ess of Facility Mo	lesworth-	Williams	Funeral Home
8 9 1 8 8		Lyan M. J	Duga		26401 Ridg	ge Road,	Damascus,	Maryland	
	in v	23a. Part1. Fer the disease or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused one cause on each lin	ne.	1-1			t,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	City Company	a consequence o	any the	ver .			6 pes
Examiner		Commentation link and distinct	Leca	ne c	entyths	lesces	/		2/0 40
p #is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence o	n):				
xecuted and al-transit	xamine	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence o	of):				
eath certificate be exattending physician for use as the buria	calE		d						
The law requires that the death certificate be the has been signed by the attending physicia bage 2 should be detached for use as the but	Physician/Medical	IF FEMALE:							
ath ce	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3□Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
at the de by the a tached t	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify) _				
s that ned by		Part II. Other significant conditions or	entributing to death be	ut not resulting in	the underlying cause given	ven in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
w requires that s been signed b should be deti	ed by	Valrule 6	lear o	Resec	D		1 ☐ Yes	2 14 1√0 3□P	robably 4 ☐Unknown
law re as bed 2 sho	Completed	Chrone 1	ent c	Valle			24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
The law cate has t	Com	Outete ne	lletes				performe 1 Yes 2	ed? death?	s 2□No
Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Ott	ner	th (Check only one)		
y Physer this eral di	: To	27. Manner of Death	28a. Date of Inju	ry 28b. T	ime of 28c. Inju	4 LI Nursing Ho	ome 5 ☐ Residen 28d. Describe how	ce 6 □Other (Spe r injury occurred	ecify)
ath. or: Afte	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	y Year) In		rk?]Yes 2 □No			
ospital or Attending P hours after death. uneral Director: After t ily filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubulding, etc.	ury - At home, far c. (Specify)	m, street, factory, office		28f. Location (Stree City or Town,	et and Number or R State)	ural Route Number,
Hospita 4 hours Funeral (ely filled	edical C	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of the basis of and manner sta	f examination and	, death occurred at the tid/or investigation, in my	ime, date and place, opinion, death occur	, and due to the cau rred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
To the Hos within 24 hor To the Fur completely	Me	29b. Signature and title of certifier	///	21	29c. Licens	se number		d. Date signed (Mon	
		mm &	LA	an.	10 0	30496		7/23/20	168
. 7		30. Name and address of nerson who s	ampleted cause of d	+ l- (IA + 00 -) (7	Time Driet)			· · · · · · · · · · · · · · · · · · ·	

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day Year) 32. Registra's Signature MAR 2 5 2008

Fun Direc

n al -	1. Decedent's Name (First, Middle, Last)						
al -					Date of Death Month	Day Year	3. Time of Dea
r '	John W. Hamilton				March 19.		11:30 F
-0	4a. Facility Name (If not institution, give street and number)		,, ,	Location of Death		4c. County of Dea	ith
	Vindobona Nursing Home			ldock Hei			cederick thplace (State or Fo.
15	5. Social Security Number 6. Sex 7. Age (In yrs. la	V	Months Days	Hours Min.	(Month, Day, Ye	ar) C	ountry)
-	219-20-4760 80 Usual Residence of Decedent)			Nov.19, 1	921 Mar	yland
- H		, Town or Lo	ocation				10d. Inside City Li
ַ בָּ	Maryland Frederick	Fr	ederick				1 □ Yes 2 X
\simeq	10e. Street and Number		10f. Zip Code		10g.	Citizen of What C	ountry?
<u>a</u>	9706 B. Hall Road		21701			United S	
Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No 195	55-	1 ☐ Yes 2/3 No	Specify:		Specify:	White
g p	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 195		dent's Usual Occup	ation	166	Kind of Business	
Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done DO NOT use retired	during most of work		. Killa of basilless	5/madsity
티	Elementary/Secondary (0-12) College (1-4or 5+)		lectricia	,		Lime	Ouarv
	17. Father's Name (First, Middle, Last)	15	rectitera		e (First, Middle, Maid		Quary
മ്	John L. Hamilton			Lottie	Kendall		
၉ -	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street		ral Route Number, Ci	ty or Town, State,	Zip Code)
	Edith Hamilton / Wife	9706	B. Hall	Rd Fred	lerick, MD	21701	
- 1	20a Method of Disposition 20b. Pl	lace of Dispo	osition (Name of matory or other place			Location - City o	r Town, State
	11 XBurial 2 ICremation 3 IRemoval from State		et Cemete	1 2/21	5/2008 _{Fr}	ederick.	Maryland
H	21. Signature of Funeral Service Licensee		2. Name and Addre		Stauffer		
	Courtney Stauller		1621 Opos	sumtown 1	Pike, Fred		
al Examiner	Sequentially list conditions, and the sequentially list conditions, and the sequential s						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ves 2 □ No 9 □ Unknown	Ideath 3 eath 5	□Ectopic pregnanc □ Other (specify) _		00 Pileb	23d. Date of d Month	Day Yea
by	Part II. Other significant conditions contributing to death but not resu	ulting in the u	underlying cause giv	en in Part I.	1 Tes		to the cause of deat Probably 4 □Unk
Completed					24a. Was an autopsy performe 1∐ Yes 2	prior to	
Be (25. Was case referred to medical examiner?		I Cu		th (Check only one)		
2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐			4 K Nursing H	ome 5 Residence		pecify)
Certification:	27. Manper of Death 1 Natural 5 □ Pending investigation 2 □ Accident investigation 3 □ Suicide 6 □ Could not be 28e. Place of injury - At ho	28b. Time Injury	M 1□	ryat rk? Yes 2∐No	28d. Describe how 28f. Location (Stree		Rural Route Number
	4 ☐ Homicide building, etc. (Specify 29a. Certifier the best of my kno	y) wledge, dea	th occurred at the t	me, date and place	City or Town, S	se(s) and manner	as stated.
Medical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	ition and/or i	nvestigation, in my 29c. Licen:			e and place, and d	
<	29b. Signature and title of certifier	MD		016675			20, 2008
	30. Name and address of person who completed tause of death (Item (I) TY NE ALGATER,	n 23a) (Type	unswide	MO	21716		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 09:40 M 8 ichard 2008 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins 617 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Nov 4, 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** New Jersey Days 1 ₹ M 2 □ F 1931 76 Yrs. 155-26-0659 Nov. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6990 Basswood Road 21703 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ሺ Yes 2 □ No If Yes, Give Year or Dates: 1953–55 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Higley Warren Dorothy Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole J. Thompson - Friend 4909 Old Barthlowes Road, Mount Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State Pleasant Hill Cemetery 3/22/08 Monrovia, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Molesworth—Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac /Medical Due to (or as a consequence of): Examiner perta Sequentially list conditions, Examiner Due to for a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1□ Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1

State Registrar Santosh

31. Date filed (Month, Day, Year)

Commen

600 North 32. Registra Signature

Physician /Medical Examiner death certificate be executed Division or Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical once.

Physician

/Medical

Examiner

MD

Director

Funeral

Completed by

Be

မ

Funeral

Director

"natural", or items 23a or 28a-f show diral E. aminer must be notified at

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-trar the for use ed by the a signed to page 2 s this within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

1 ☐ Yes 2 ☑ No 9 ☐ Unknown		ctopic pregnancy htther (specify)		23d. Date of delivery Month Day Year
	ontributing to death but not resulting in the under pulmonory descave	erlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknow
	<u> </u>		24a. Was an autopsy performed 1∐ Yes 2	
25. Was case referred to medical examiner? 1 ✓ Yes 2 ◯ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othor	eath (Check only one) Home 5 Residence	6 □Other (Specify)
27. Manne Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier Check only one) Certifying Phy	vician: To the best of my knowledge, death o iner: On the basis of examination and/or investant manner stated.	ccurred at the time, date and pla stigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number 29c		Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Hospital or Attending

Oxon Hill Mary land.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

T. Cullen

MAR 24

Loward

31. Date filed (Month, Day, Year)

6188 0x00

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 8:30P March 12, 2008 Gladys Jones /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Spring
If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Silver If Under 1 Year Montgomery Apex Health of Silver Spring Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 ☑ F 89 May 7,1918 SC Director 577-16-9770 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or items 23a nr 200 any injury or other treumetric next. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 XYes 2 No Director Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 20910 United States Funerai 2700 Barker Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 TNo Specify: þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Switchboard Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lila Wilson Thomas Boozer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4300 Brinkley Road
Tample Hills, Nd. 20746

20b. Place of Disposition (Name of cemetery, crematory or other place) Vivian Sills/niece 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cem. 3/18/08 Suitland, Md. 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service License 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Party. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ALZHEIMERS Immediate Cause (Final disease or condition resulting in death) Unknown Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) Yes 2 No 9 I Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 🗌 Yes 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification; To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fun completely 1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 043121 Chowdly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NURUL CHOWDHURY, MD; 15216 DINO DRIVE BURTONSVILLE, MD 20866 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 0 2008

DHMH 17 Rev 1/2001

Registrar

State Registrar

7500 Greenway Center Dr. #430 Greenbelt, MD 20770 Peter M. Schissler, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signat MAR 2 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** ${\tt A}^{\sf M}$ GLORIA **JEAN** KING March 22, 2008 7:27 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 12 F Director 213-30-7577 75 May 12, 1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Carrol1 Mt. Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4112 Boteler Road 21771 United States Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Iter 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White If Yes, Give Year or Dates: Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Operator Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Roland Wesley Welsh Irene Elizabeth Mullinix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aubrey King / Husband 4112 Boteler Road Maryland 21771 Mt. Airy, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 27, permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery 2008 Mt. Airy, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Sign were of F Mt. Airy, Maryland 21771 8 E. Ridgeville Blvd. 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PERTENSION UNKNOWN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner death certificate be executed as the burial-transi and Due to (or as a consequence of): ed by the attending physician detached for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RO DE 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1∐ Yes 2XX No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760. P.O. I Division or Vital Records, To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2.

State

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

Rusu Florin, M.D.

loun

32. Registra 's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

400 W. Seventh Street Frederick, Maryland 21701

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 2:45 P M March Edward W Kefauver /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, July 5, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**★**M 2□F 94 Yrs. Maryland 220-01-1228 Director Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1√Yes 2 No Maryland Frederick Frederick Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naveranty injury or other traumating once. USA 356 Park Avenue 21701 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🗷 No Specify. Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Bus Driver** Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Marie Hobbs Jacob Wilmer Kefauver ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward Kefauver - son 1006 Eastbourne Court, Frederick, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Lutheran Cemetery 3-10-2008 Middletown, Maryland 4 □ Ø onation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bladder Conce Immediate Cause (Final disease or condition resulting in death) 1BARS Physician /Medical Due to (or as a consequence of): DAYS **Examiner** EMATURIA Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ral Director: After this cralled in by the funeral dire 1 ☐ Yes P No 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi DOO 62223 3/5/08 a) (Type, Print) 19675 DRIVE, PREDENICE, MD 21702

State Registrar

8

32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 0 7 2008

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOLANUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 🖰 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 2008 **Physician** 4 07:49 AM KUMMEL BARBARA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery 8508 Goshen View Drive Gaithersburg 8. Date of Birth (Month, Day, Year) Sept. 4,1952 If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funeral Days 1 □ M 200 F 55 Maryland Director 218 52 5733 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ? is marked other than "natural", or iteme 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Md. Montgomery Gaithersburg Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 United States 8508 Goshen View Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiene.
Hygiene.
Inher than "natural, or itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygiens Importent: if item 27 is marked other that eny injury or other treumatic event. Animal Dermatology 12 Veterinarian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elberth Kummel Anne William John ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8508 Goshen View Drive, Gaithersburg, Md. 20882 Robert R. Banks, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 3/5/08 Alexandria, Va. `4 □ Donation 5 □ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home m-00470 Laytonsville, Md. 20882 agree P.O. Box 5038 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Ponknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Yes 2 1 No Division of Vital or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one, 1 Nes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospitel or Atterwithin 24 hours after des To the Funerel Director completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of centifier 29c. License number

State

31. Date filed (Month, Day, Year)

MAR 0 7 2008

32. Registrar's Signature

mn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anoth

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Registrar

DME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 18 1:50 P. M Robert Lee Keiser March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospice, Inc. Dove House Carroll Westminster 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, July 2, 19 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country, PA Days Hours 209-24-1471 1**X**M/ 2□ F 1931 Director 76 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County if Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☑ No Carroll Maryland Woodbine Director 10e. Street and Number 10g. Citizen of What Country? 1368 Hoods Mill Road 21797 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other fraumatic event, the Medicial Examiner must by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
15 Yes 2 □ No 1950 17 Yes, Give
Year or Dates: 1953 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2CONo Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+) Ford Motor Co. Auto Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Henry Keiser Mabel Brown မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Keiser brother 1368 Hoods Mill Road Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. March 24, 2008 Owings Mills 4 Donation 5 ☐ Other (Specify) 21. Sign wure of Funeral Service Lice Burrier-Queen Funeral Home & Crematory 1212 W. Old Liberty Road Winfield. , PA MD 21784 Approximate Interval Between Onset and Death Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iate Cause (Final ance **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Uniterrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed signed by the attending physician and defacted for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I 1 Yes 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA ٩ 6. Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural Injury 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSZ 280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wistmister ilbu

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylar	•	artment of H		nd Me		ene . No O (8 (11183	
	Physici	an	1. Decedent's Name (First, Middle,							Date of Death Month	Day	Year	3. Time of Death	
	/Medic				n Gertr	ude Lus				Month Februar			7:30 P M	
	Examin	ier	4a. Facility Name (If not institution, Williamsport N				4b. City, Town, or					naton		
	Funeral			6. Sex		Williamsport e (In yrs. last birthday) If Under 1 Year If Under 24 Hrs				Date of Birth		Washington 9. Birthplace (State or Foreign Country)		
	Director		214-14-6930	1□M 2½□F	97	Yrs.	Months Days	Hours	Min.	(Month, Day, Year) Feb. 24,191.			ryland	
	pu s		Usual Residence of Decedent 10a. State 10b. County	-	10c. Cit	ty, Town or Lo	ocation					1	0d. Inside City Limits	
	Aaryli f eho	ō		hington	1,00,0	.,,	Hager	stown					1 √Yes 2 No	
	128a-	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of W	/hat Coun	ntry?	
	th with	ai D	240 South P	otomac S	treet		217	40			U.S	.A.		
	r dea	Funerai	11. Marital Status	12. Was De	cedent Ever in U	l.S. 13.	Was Decedent of H	ispanic Origi an, Mexican,	in? (Specif Puerto Ric	y Yes or No- an, etc.)		Americ k, White,	ean Indian, etc.	
36	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28a-f ehow te Medical Eram har must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ※ Widowed 4 ☐ Divorced	ed 1 ∐Yes If Yes, G Year or	2 ☑ No live		1 ☐ Yes 2 ☑ No	Specify:			Specify:	: Б	Mite	
9	2 hour	ed t	15. Decedent'	s Education			dent's Usual Occup				b. Kind of Bu			_
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Maryland 21215-0036	I be fii ntai H ed oti	Be	17. Father's Name (First, Middle, L Elmer Stitz						•	First, Middle, Ma Che Poo.		e <i>)</i>		
<u> </u>	should nd Me mark matic	2	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street					State, Zip	Code)	
Z	alth ar 27 is 17 is			Daughter)		oodlyn La.							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Pages. Pages.		20a. Method of Disposition	2 Damous from	20b. F	Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	Date	ch 1,	c. Location -	City or To	wn, State	
Ĕ	Page ment ant: i		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	Sm	ithsbui	rg Cremat	ory	200		Smiths	sbur	, Marylan	d
3a	ermit. Depart mport ny Inj		21. Signature of Funeral Service L	icensee			2. Name and Addres		U	.L. Dav				
	40 = 0 G	-	23a. Part1. Enter the disease, or	complications that	caused the deal	-	2525 Brad					ary1a	Approximate	_
	Physician /Medical Examiner		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to	neumo (or as a consec	n(a_ quence of):							Interval Between Onset and Death 3 weeks	
SU,	sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	o (or as a consec	juanca of).								
58760,	ficate be ex physicien s the buria	dical		d										
P.O. Box 6	Attending Physicien: The law requires that the death certificate be executed refeath. refeath. ector: Attenthis certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	utcome of pregnation in the pregnant at time of conown	aldeath 3□	Ectopic pregnancy Other (specify)				23d. Date Mor	e of delive	ery Day Year	
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Vita	sertor, ector,	Be	25. Was case referred to medical examiner?	Hospital:			10.			Check only one)				
ot	Physi this c al dira	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 28a. Date		ER/Outpatier		4 (# NUIS		5 Residen			/)	_
o o	ding th. After fune	tlon	1 Natural 5 Pending 2 Accident investig) (Mo.	nth, Day Year)	Injury	Worl	yat k? Yes 2 ∐ No		u. Describe now	injuly occurre	0 0		-
Divisi	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	ce of Injury - At h ding, etc. (Speci		reet, factory, office		28f	Location (Stre City or Town,		er or Rura	al Route Number,	
	Hosp 14 hou Funei Tely fill	dicai	(Check only 2 Medical E	xaminer: On the	basis of examina	wledge, death ation and/or in	h pegumed at the tim vestigation, in my o	ne, date and pinion, death	place and	due to the rau at the time, dat	se(s) and man e and place, a	and due to	ated the cause(s)	
	ithin 2 the the	Med	one) 29b. Signature and title of certifier		nner stated.		29c. License	e number		290	d. Date signed	I (Month.	Day, Year)	-
	F ₹ F 8		Cynthia !	Luttner	,-San	do, mo	D	4749	91	F	ebrua	142	9,2008	
	^	1	Opnthia /. 30. Name and address of person of Cynthia Kuthn.	vho completed car	use of death (Iter	n 23a) (Type,	Print) , A/.	102110	Non	ne, 15x	North	Ar	tizan. Strei	2 4
-	2	1	Cynthia Kuthn	er-Sanc	ds, MD	William	1sport	Willi	iams	port 1	Maryl	and	21795	
9	Sta Registr		31. Date filed (Month, Day, Year)	JZ.	Registrar's Signa	ature				,	,			

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Req. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 14, 2008 FELICIA CONSTANTINA LEVERETTER - FORD MARCH 10:25A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGES If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Days 1 M 200 Months 39 Yrs. Director 251 51 5731 AUG. 1968 SOUTH CAROLINA 14, Usual Residence of Decedent be filed within 72 hours after death with the Maryland all Hygiene.

other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shedical Examiner must be notified XXYes 2 □ No Directo PRINCE GEORGES BELTSVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12102 BENJAMIN STREET 20705 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify Specify: BLACK þ 3 ☐ Widowed XX Divorced Year or Dates: Completed er than "natur t, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT/ Elementary/Secondary (0-12) College (1-4or 5+) CONTRACT SPECIALIST 1+ INTERNAL REVENUE SVC. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be JOHNNY LEVERETTER P BEATRICE LIVINGSTON 19a. Informant's Name/Relationship (Type. Sint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA L. TIMUS / -DAUGHTER 12102 BENJAMIN ST. BELTSVILLE, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State McKeever Funeral Home 103-19-2008 4 Donation 5 Dother (Specify) Conway, SC 21. Signature of Funeral Sonice Liq 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Parti. Enter the disease, o shock or heart failure. Lis implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ily one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a.METASTATIC BREAST CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unuellying Cause (Disease or injury that initiated events. Due to (or as a consequence of) Examiner death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) burial-Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? for Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 No 9 ☐ Unknown 9☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 No 3 Probably ★XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? page certificate Division or Vital 1□ Yes 🟋 🗙 No Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA ٩ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending (Month, Day Year) Injury XXNatural 5 Pending A hours after dea.

*eral Director: δ

'n by the investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospital XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

7300 VAN DUSEN ROAD

wm

32. Registrar's Signature

30. Name and address of person who completed cause or death (Item 23a) (Type, Print)

THOMAS H. BURGUIERES, M.D.

2008

31. Date filed (Month, Day, Year)

MAR 2 0

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LAUREL REGIONAL HOSPTIAL, EMERGENCY DEPT. DUSEN ROAD LAUREL, MD 20707

C/-(3)

State 31. Date filed (Month, Day, Year)

Registrar MAR 2 0 2008

ALAN R SEGALL



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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CR 3

State Registrar ashas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Farhad Jamali, M. D., 7525 Greenway Center Dr., Greenbelt, Md. 20770
31. Date filed (Month, Day, Year)

MAR 2 0 2008

2005 8213

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10b-f Per FH G878 4/22/this att of Death Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 3 2008 **Physician** 11:23 AM March Dorothy Ann Lindbeck /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours West Virginia 1□M 2⊠F Davs Director 92 1915 572-36-6762 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Frederick 1 XIVes XX No Director Maryland Prince Georges Temple Hills Frederick 10e. Street and Number 5997 Ladd Ct. Apt A 10f. Zip Code 10g. Citizen of What Country? 21703 20748 4809 Sharon Road United States Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify: White þ 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Church Pre-School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Roy Wright Grace Nellie Adkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5997 Ladd Court, Apt. A Frederick, Maryland 21703 Debbie Kerns / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 7, 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 2008 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath Immediate Cause (Final Physician IVE neumonia disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the buriaf-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the a d be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 ☐ Yes 1□ Yes 2 No 2 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ၉ al or Atte.

Ars after death.

Aral Director: After th?

by the funer. 28a Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Characteristying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

To the Hospital of within 24 hours at To the Funeral D

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DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

Robert L. Kaufmann,

MAR 0 7 2008

ause of death (Item 23a) (Type, Print)

an

M.D.

32. Registrar's Signature

29c. License number

300 W. 9th Street Frederick, Maryland 21701

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State	of Maryland		artment rtificate			and M		giene Reg. No.	08	88
		Decedent's Name (First, Middle	Last)							2. Date of Dea	ath		3. Time of Death
Physici		Margaret Metz	Litton							Month March	Day 21	2008	11:30P™
/Medio Examir		4a. Facility Neme (If not institution,		um <i>ber)</i>		4b. City, T	own, or	Location of	of Death		4c. Coun	ty of Death	
		NMS of Hagers	town					gerst					n County
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 X ☐ F	7. Age (In yrs. la		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	Coun	lace (State or Foreign
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Pour ture	pa pa	15. Decedent		Dates.	16a. Dece	dent's Usual	Occupa	ation			16b. Kind of	Business/Inc	dustry
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Mal d 2 sho th and 7 is ma treum		19a. Informant's Name/Relationsh		dauahtan		-				al Route Number			code) yland 21767
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/Medical		disease or condition resulting in death)	a	o (or as a consequ	uence of):		_	+10	. \	6:04	0:5	1.664	
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DO /			a										
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by the	hys	9 🗆 Unknown								00 Did			he cause of death?
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To the within 2 To the complet	Med	29b. Signature and title of certifie		anner stateu.				e number			29d. Date sig	ned (Month,	Day, Year)
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		30. Name and address of person	who completed ca	ause of death (Item	1 23a) (Type	, Print)							
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	ate	31. Date filed (Month, Day, Year)		. Registrar's Signa	ture	1				0			-
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day JUNE LANG LICHLITER 24, MARCH 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death WASHINGTON BOONSBORO REEDERS MEMORIAL HOME Months Days Hours Min. SEPT. 6, 1930 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 F Months VTRGINIA 224-34-8495 77 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 1 Yes 2 No **SMITHSBURG** WASHINGTON MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 4 BLUE MOUNTAIN ESTATES U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify Specify. WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FREDERICK SYLVESTER REYNARD MELLIE MAE LANG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11100 MAPLEVILLE ROAD, HAGERSTOWN, MD DENISE KELLER, DAUGHTER 20a. Method of Disposition 1 ➡ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) CEDARWOOD CEMETERY 3/28/2008 EDINBURG, VIRGINIA 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713 BAST FUNERAL HOME Approximate Interval Between Onset and Death 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List nly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myo Canded 1-21fm Sequentially list conditions, if any, leading to finnediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) YEARU. IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 █**X**No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical **Examiner**

permit. Pages 1 and 2 a Department of Health at Important; if item 27 is any injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ō

or items 23a

other traumatic event, the Medical Examiner must be notified at

1 and 2 should be filed within 72 hours after death veath and Mental Hygiene. 9m 27 Is marked other than "natural", or Items 23

Funeral Director

Completed by

Be ျှ

with the Maryland

Examine Physician/Medical þ Completed Be Certification: To Medical

ending physician and use as the burial-tran After this within 24 hours after death To the Funeral Director:

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

OH-3

death.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

28a. Date of Injury (Month, Day Year)

29c. License number

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Nursing Home 5 □ Residence 6 □ Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470 20311 GHAZALA QADIR,

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 ☐ Yes 2 No

27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Natural

MAR 26 2008

5 ☐ Pending investigation

6 Could not be determined



ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:20 ам Louise Mary Leigh 23,2008 March 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Golden Living Center Hagerstown, Washington If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex Age (In vrs. last birthday) MD Country) Hours 2-8-1918 Days Min. 220-09-8025 1 ☐ M 25 F 90 Usual Residence of Decedent 10a. State MD 10c. City, Town or Location 10b. County 10d. Inside City Limits Washington Hagerstown 1 Yes 2 No 10f. Zip Code 21740 10g. Citizen of What Country? 10e. Street and Number 750 Dual Highway U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give X Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married swhite 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) air craft mfg. Elementary/Secondary (0-12) College (1-4or 5+) assembly worker unknown unknown 17. Father's Name (*First, Middle, Last)*Vernon Thomas Mills 18. Mother's Name (First, Middle, Maiden Surname) Blanche Victoria Shoemaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 Green Valley Dr. Charles Town, WV Herman Leigh nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peters Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hancock, MD 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur funeral Service Lice 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O.BOX 310 Clear Spring, MD 21722 Immediate Cause (Final 5 years disease or condition resulting in death) Due to (or as a o quence of) Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If ves, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

death certificate be executed

P.O. Box 68760

Division or Vital Records,

Physician:

or Attending

Hospital

WH-4

death.

within 24 hours after death To the Funeral Director:

within 24

Medical

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show diral Examiner must be notified at

the Medical

than,

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

attending physician and for use as the burial-trans i signed by the ai been a has After this certificate director,

Examiner Physician/Medical Completed Be 2 funeral Certification: filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 ☐ Unknown

1 Yes 2 No 27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

6 Could not be determined

auren

1 Inpatient 28a. Date of Injury 5 ☐ Pending investigation (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) muil strul- Heigenstenn 1912/740. MANZAR. 368 2 SITUAFI

31. Date filed (Month, Day, Year) MAR 2 6 2008

32. Resstrar's Signature



Registrar

DHMH 17 Rev 1/2001

08-02513			or Print in Black					ible.	
Raymond Emme		- For State Registrar		epartment o Certificate o			Reg	. No.	8 1119
Physicia Medical Exami		Decedent's Name (First, Middle,L Paymond	Emmett Loyd				2. Date of Death Month I March 30, 2	Dav Year	3. Time of Death 1340 hrs
(4a. Facility Name (if not institution, g			4b. City, Town, o	r Location of Death	Walcii 50, 2	4c. County of Deat	h
, 		219 West Maple Heights			Rising Sun			Cecil	
Funeral Director		010 00 5001	, _	rs. last birthday) 7	If Under 1 Year Months Day		-	(MM/DD/YYYY) 9. Bi 0, 1961 Forei	
Birestor	-	Usual Residence of Decedent	7 M 2 F 4/	Yı	rs.		Jan. Z	0, 1001 0	ountry) 1 ID
v any	ı	10a. State 10b. County		City, Town or Loca					10d. Inside City Limits
land -f shov	ţ		cil	F	Rising Su	n	T40	O'stime of Milest Co.	1 Yes 2 No
e Mary or 28a	Director	10e. Street and Number 219 West Maple	Heights		10f. Zip Code 6108	s()	100	o. Citizen of What Cou US	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Halth and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status	12. Was Decedent Ever		/as Decedent of H	ispanic Origin? (Sp		14. Race - Ame	rican Indian, Black,
death or item	Funeral	1 Never Married 2 Marri	1 Yes 2 1	No _	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	White, etc.	
s after rral", o	٥		ed If Yes, Give Year 1981		Yes 2 N	o specify: ation (Give kind of w	ork done	Specify: 16b. Kind of Business	White
2 hour "natu	jed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)			e. DO NOT use retir		TOD. KING OF BUSINESS	/ilidusti y
036 athin 7 ene. er than Medio	Completed	12			Lineman			Electr	rical
filed w Hygid other		17. Father's Name (First, Middle, La Raymond S. Loyd		-		18.Mother's Name Elma Mo		aiden Surname)	
212 uld be Menta marke	o Be	19a. Informant's Name/Relationship		19b. Maili	ng Address (Stre			per, City or Town, Stat	te, Zip Code)
MD 12 sho 17 is umati		Raymond S. Loyd				ve., Camb			
ore, s. l. and of Heal		20a. Method of Disposition 1 Burial 2 Cremation	Removal from State	20b. Place of Dispo crematory or o	other place)		Date	20c. Location - City of	
Limo Page ment c		4 Donation 5 Other Spec	ify:					Cambridge	e, MD
Ball permit Depart Impor		2) Algnature of Funeral Service Lic	ensee Brans	118 22	Name and Address Curran-Br	onwell Fu	meral H	ome, P.A. MD 21613	
Physician		23a. Part I. Enter the disease, or co		leath. Do not enter	the mode of dying	g, such as cardiac of	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		fallure. List only one cause on Immediate Cause (Final disease	a.Hypertensive At	herosclero	otic Cardio	wascular Di	sease		Death
Administ		or condition resulting in death)	Due to (or as a consequer	nce of):					
	ē	Sequentially list conditions, if any, leading to himsediate	Due to (or as a consequen	tce of t					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequer	nce of):					
cuted ind transit		events resulting in deathy least	d.	·					
be exe	dice	X UNPENDED	AMENDED 23a,Pt.	.II,27 per	ME g878 4/	9/08 amh			
Box 68760, c death certificate be execute the attending physician and ed for use as the burial - tran	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		Fetal death 3	Ectopic pregna	ncy	23d. Date of delive Month	ery Day Year
OX 6	sicia	past 12 months? 1 Yes 2 No 9 Unkno	Pregnant at time	-6 -1	Other (Specify)				
b. Be the des	Phy	Part II. Other significant condition	9 Olikilowii	not resulting in the	e underlying cause	given in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
s, P.O. Be irres that the de signed by the	d by	Cirrhosis of the 1	iver				1 Yes	2 🗸 No 3 🗌 Pr	obably 4 Unknown
cords, law requir has been s	Completed			-			24a. Was a		autopsy findings available o completion of cause of
He law	omp						perform		Yes 2 No
Vital Rec ysician: The his certificate	BeC	25. Was case referred to medical examiner?	lleeshel.			ce of Death (Check			
of Vital Records, P.O ng Physician: The law requires that the this certificate has been signed by meral director, page 2 should be detacted.	မ	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie		Other Nursin		Residence 6 V Oth	ner: Scene
on of anding Pl th. r: After	tion:	1 X Natural 5 Pending	(Month, Day, Year)	200. 11110		Yes 2 No		,,	
Division tal or Attendir us after death. al Director: A	fica	2 Accident Investig 3 Suicide 6 Could r	28e Place of Injury	- At home, farm, st	reet, factory, office	building, etc.			Rural Route Number, City
Division of ' Hospital or Attending Ph 24 hours after death. Funeral Director: After tely filled in by the funeral	Certification:	4 Homicide determi	ned (Specify)				or Town, St		
Hos 24 h Fun tely		29a. Certifier (Check only one) 1 Certifying Physical Exami	ician: To the best of my knowner. On the basis of examina	owledge, death occition and/or investig	curred at the time,	date and place, and on, death occurred a	due to the cause t the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
To the within ? To the comple	Medical	29b. Signature and title of certifier	and makiner stated.			nse number		29d. Date signed (A	
		/ //	1		1 00	ME		March 31 200	0

DOME

Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Mary G. Ripple MD. Deputy Chief Medical Examiner

State 31. Date filed (Month, Day, Year) 2008

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 31, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 03 O 24 Ž0'08 4:30 am Musa Kadija /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Takoma Park, MD Montgomery Washington Adventist Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Min. | 11/20/1946 | Sierra Leone 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🗙 F None Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at Hyattsville Prince Georges 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Examiner must be 20782 Sierra Leone #U2 23a 3600 Dean Dr. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 TNo Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed None other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hamoud Sulaiman Fatima Musa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Department of Health ar Important; if Item 27 Is any injury or other trauonce. Adel Musa / Brother 14407 Dunstable Ct. Bowie, MD, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington 03/09/08 Adelphi, MD 4 ☐ onation 5 ☐ Oth (Specify) 22. Name and Address of Facility Universal Mortuary Inc. 21. Sign ur of Funeral S License 411 Kennedy St. NW Washington, DC 20011 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Perforated Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of s certificate has b irector, page 2 sl 24a. Was an autopsy death? 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 ☐ Yes 2 ☑ No 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury after death.

I Director: At d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61623

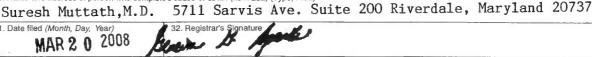
State Registrar 31. Date filed (Month, Day, Year)
MAR 1 7 2008

MAR 1 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carroll Are #270 Talcoma Park MD Jegiz

State Registrar 31. Date filed (Month, Day, Year) MAR 2 0 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#2.829d. PerPhys. PCC3-20-08cr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 03 Noore 5-Mar. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner (an poli 1 LIMA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 262-74-2268 63 Nov. 1944 Kansas Director 6, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene. Agranging ordent: If item 23a or 28a-f show ordent: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, ithe Medical Examiner must be notified at injury or other traumatic event, ithe Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 700 Linden Grove Place, Apt. 101 21113 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1963–67 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: ģ 3 ☐ Widowed 4 🏲 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosemary Boyer John C. Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Linden Grove Pl., Apt. 101 Odenton, MD Melissa L. Moore/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Metropoitan Crem. 3/19/2008 4 □ Donation 5 □ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic /Medical Due to (or as a consequence of): **Examiner** -obstruc 400 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown aleng 1 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 2 No Medical Certification: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March completed cause of death (Item 23a) (Type, Print) 1001 ParkWAY Midlent 32. Registrar's Sign 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2008

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Λ	(2)		30. Name and add	ress of person wh	o completed cau	se of de	eath (Item	23a) (Ty	pe, Prir		<u> </u>		11 (- 1	2	+ 1	- 6			270
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3, 2008 Malinda R. Massey March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Futurecare Pineview Nursing Home Clinton Prince Georges 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🗙 F Days Hours Director 30,1911 577-16-1204 Wash.,DC March 96 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director Clinton Md. PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9106 Pineview Lane United States Funeral 20735 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 1.2 Elevator Operator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick J. Edmonds Pages 1 and 2 should ပ Estella B. Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12903 Blackwater Terrace Georgianna Massey/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 3/21/08 Suitland, Md. 22 Name and Address of Facility Hodges & Edwards F.H. 21. Sigrature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md.20746 23a. Parn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and Due to (or as a consequence of): burial-1 P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Dav 5 ☐ Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 2 No 3 Probably 4 Unknown 1 □ Yes Completed been a 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performe this certificate 20 Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending (Month, Day Year) 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Certifying Physician: 10 the best or my knowledge, death occurred at the time, date and place, and due to the cade(s) and mainten as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature appd title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) State MAR 2 0 2008



address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 2008 9:38 а м Judy E. Marshall 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 16, 1951 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🖰 F 226-74-6966 56 Yrs. Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Mt. Rainier 1⊠Yes 2□No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20712 3123 Queens Chapel Road #201 12. Was Decedenf Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Technician Giant Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter R. Whited Dulacy Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\overline{0712}$ 19a. Informant's Name/Relationship (Type, Print) Rolf Marshall-Husband 3123 Queens Chapel Road Apt. 201, Mt. Rainier, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/19/2008 Richardson Cemetery Swordscreek, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4739 Baltimore Ave., 21. Signature of Funeral Service Licensee Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Daschdanning The 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mnocandia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performet? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check onfi one

Physician /Medical Examiner

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or Attending Physician:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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r than "natural, or items 23a or 28a-f show the Medical Exactions must be notified at

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permit. Page Department of important: if any injury or once.

Baltimore, Maryland 21215-0036

Director

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Completed

that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 No 27. Manner of Death

6 Could not be determined

1 🗆 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of 28c. Injury at Work?

2 XER/Outpatienf 3 DOA

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and dire to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 046998

29d. Date signed (Month, Day, Year) Markch 12,2008

30. Name, and address of person who completed cause of death (Item 23a) (Typa, Print)
Stuum Tee, MD 3415 HAM11 HM ST HYA HSVIIL, MDZ0782

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Helen Mursh Month **Physician** E 22, 2008 12:30P ^M Mar. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Keedy Washington Fahrney

5. Social Security Number Boonsboro 8. Date of Birth Month, Day, Year 1918 Birthplace (State or Foreign County) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min 220-28-8712 1 □ M 2 🙀 F 89 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No MD Frederick Burkittsville Funeral Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 6104 Mt. Church Rd. 21718 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 3 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify. ò Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other this any Injury or other traumatic event, the once. homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence McGowan Rhoda Sigler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lloyd Murphy (Husband) 6104 Mt. Church Rd., Burkittsville, MD21718 20h. Place of Disposition (Name of Languages drematical or other wace) 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 ☑ Burial 2 ☐ Cremation 4 □ Dopation 5 □ Other (Specify) Bible Church Cemetery Middletown, MD 21. Signalul of Fundal rvio 2) Name and Address of Facility ompson Funeral Home P. O. Box 18, Middletown, MD 21769 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Dementia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a cons quence of) Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2**X** No Completed Degenerative arports 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check on one) 30. Name and agriress of person who completed cause of death (Item 23a) (Type, Pint)

Zafav Malik Mp 2031) Cappams Rd Boonshoo Mp 21713

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 2 5 2008 29c. License number 29b. Signature State

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore,

Records, P.O.

Vital

Division or

DHMH 17 Rev 1/2001

Registrar

6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	Marylan		artment of F rtificate of a			giene Reg. No.	008	11200
		-		me (First, Middle, La	ast)					2. Date of De	eath	Vear	3. Time of Death
	Physicia /Medic	_	Peter Jan	mes Moske	1, Jr.					Marcl	n 21,	2008 ear	8:30 A M
	Examin		,	(If not institution, gl		er)			r Location of Death	1		ounty of Death	
7532			5. Social Security I	l Baltimo		Age (In yrs.	last birthdav)	Olney If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	tgomer	y place (State or Foreign
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Man	a-f sh ified	ctor	VA	Arlingto	n	Ar1:	ington						1 ☐ Yes 2 ☐ No
ith the	or 28 se not	Director	10e. Street and Nu					10f. Zip Code				n of What Cou	intry?
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ages 1 an	Department of Heatin and Mentar Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.			sposition 2 MCremation 3 [5 □ Other (Spec		ato C	cemetery, crei	osition (Name of matory or other place ke Cremat		Date 22/08		tion - City or T	•
Dallillo	Departme mportan any injur			uneral Service Lice		4	Ĝ	2. Name and Addre	ess of Facility Cremati	on Serv			
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The law re	te has bee age 2 sho	Completed								24a. Was auto perf 1 Yes	s an opsy formed? 2 2 No	24b. Were aut prior to c death? 1 ☐ Yes	topsy findings available completion of cause of
VII.	ertifica ctor. p	BeC	25. Was case reference	erred to medical					26. Place of Dea			1 1 1 1 0 0	
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To the Hospital or Attending	within 24 nours arter beam. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigatio 6 ☐ Could not l determined	be 28e. Place of	f injury - At h g, etc. <i>(Speci</i> i	ome, farm, str	reet, factory, office	res 2 No		(Street and i	Number or Ru	ıral Route Number,
Hospita	24 nours Funeral stely filled	Medical C	29a. Certifier (Check only one)		Physician: To the baseminer: On the base	is of examina							
To the	within To the compl	Me	29b. Signature an	nd title of certifier	1	10	-/-	29c. Licens	se number		29d. Date	signed (Month	h, Day, Year)
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(P) 0'	2		/	dress of person who					Rockvill	.e, MD 2	0850		
	Sta		31. Date filed (Mo	onth, Day, Year)	32. Re	istrar's Signa	ature						
	Regist	rar		MAR 2 5	2008	alless.	15 16	barles					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month Year **Physician** March 19, 3:15 P Margaret Mary Musgrove /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 167 Cardamon Drive Edgewater 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F 96 08/15/1911 Washington, D.C. 577-20-0494 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No r 28a-f sh notified Directo Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or iury or other traumatic event, the Medical Examiner must be not per traumatic event, the Medical Examiner must be not be read to the medical Examiner must be not be read to the medical Examiner must be not be not be not the medical Examiner must be not 167 Cardamon Drive 21037 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 Widowed 4 □ Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hilgenberg Annie Ritmeyer ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Poole/Granddaughter 167 Cardamon Drive, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/24/2008 Annapolis, Maryland St. Mary's Cemetery 21. Signature of Muneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by No. 1 TYes 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has RIPHE ACCIDENT 1☐ Yes or Vital Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2 No Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 5 Residence 6 ☐Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 2 Accident Injury 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the f

29a. Certifier Medical (Check only one) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) 003637

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDGEWATER MD 21037 BRAVERTON ST 201 ANFERMO LAYMOND

State Registrar

Q^Vi

31. Date filed (Month, Day, Year) MAR 2 1 2008 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** $5:15 a^{M}$ 16, 2008 Dugan Morris March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chevy Chase Manor Care-Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 ☐ X 90 1917 Director 217-34-0651 19, Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Annapolis Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 USA 708 Rosedale Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: White ģ ₩idowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeremiah J. Dugan Nellie F. Hurley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 708 Rosedale Street, Annapolis, MD 21401-2300 Anne E. Morris/Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 26 1 € Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2008 Silver Spring, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd., W, Silver D 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Probable Sepsis resulting in death) Due to (or as a consequence of): Urinary Tract Infection Sequentially list conditions, if any least 1 cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 2 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

certificate be executed

Box 68760

P.0.

or Vital Records,

Division

Attending Physician:

Hospital or

To the Vithin 2

a or 28a-f show t be notified at

items 23a

r than "natural", or items 23a the Medical Examiner must I

Maryland 21215-0036

Baltimore,

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12 should be filed w h and Mental Hygier 7 Is marked other th

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

burial-transit and attending physician as the nse ned by the attent page 2 should be de within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

1 ☐ Yes 2 No 27. Manner of Death

1 Inpatient 28a. Date of Injury 28b. Time of (Month, Day Year)

28c. Injury at Work?

1 □ Yes 2 □ No

28d. Describe how injury occurred

Avenue, #1-17, Silver Spring, MD 20902

26e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

D54566

March 17, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia

2008

Sunitha Bhogavilli, MD 31. Date filed (Month, Day, Year)

MAR 24

32. Paistrar's Signature

State Registrar

Certification:

Medical

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** MCNEILL VIRGINIA MILDRED 03 22 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMAN SUBURBAN HOSPIOTE BETHESDA Months Days Hours Min. Feb. 12, 1928 9. Birthplace Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖫 F 230-32-6596 80 Virginia Director Usual Residence of Decedent show 10c. City, Town or Location 10a State 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2 N No Director Maryland Montgomery Montgomery Village 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Examiner must be 18615 Walkers Choice Road, 20886 USA 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 9 White 1 ☐ Yes 2 ☐ No Specify: Specify: <u>A</u> 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Owner Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be fill and Mental H Refa V. Craun Health and Menta em 27 is marked Price A. Liskey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn E. Thompson/Daughter 831 Snider Lane, Silver Spring MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 29 permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Surial 2 □ Cremation 3 Removal from State Prospect Hill Cemetery 4 Donation 5 Dother (Specify) 2008 Front Royal, VA 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATION FAILURE Physician /Medical Due to (or as a consequence of) Examiner MADLY ACCOURSIVE BRONCHOTORVEDLYE CHICAC 6 MONAGO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MUCUS PLUGGING PHEUMONIA. 1 ☐ Yes 2 ☐ No 3 ₹ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**\to**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred (Month, Day 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled ir 1 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 22,2008 all

State Registrar 31. Date filed (Month, Day, Year)

2008 MAR 24



Baltimore, Maryland 21215-0036

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Vital Records,

or

Division

Physician:

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 20, 2008 **Physician** Malcolm I. Nagle, Jr. 8:30 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7221 Mountaindale Road Frederick Frederick if Under 1 Year if Under 24 Hrs. Months Days Hours Min. Oct. 29, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ▼M 2 □ F 69 176-30-1952 1938 Director New Jersey Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 7221 Mountaindale Road USA or items 23a Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural", Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than Marketing and sales Telecomunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Malcolm I. Nagle, Sr. Theophane Ann Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7221 Mountaindale Road, Frederick, Maryland 21702 Mary Jane Nagle - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If Ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Utica 3-26-2008 Utica, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 lue 1621 Opossumtown Pike, Frederick, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DRONARY ARTEKV 2 YRS DIJEME disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and -trans physician ar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as signed by the attending pages as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIVERTICULOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performed? this certificate 1 Yes 2 No director 25. Was case referred to medical 26. Place of Death Check onl one Be examiner' Other: 4□ Nursing Home 5□ Residence 6 図Other (Specify) Residence 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 1 Natural (Month, Day Year) 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident the Funeral Director: npletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide after Hospital hours 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/24/08 021936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+1 A. DINELSON, 65c Thomas DR, FREDBRICK. mo VO HNJON 21702 31. Date filed (Month, Day, Year) 32. Registrans Signature 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/MEND#10eperINF,4-1-08,HWW,MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 09:40 AM A WAIT AT 21 03 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday If Under 1 Year Months Days Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Hours Director 212-39-7073 86 Russia Sept. 15, 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo -28a-f Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. #309 17060 King James Way U.S.A. 20877 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 X Widowed 4 Divorced Year or Dates: Asian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Quality Controller Textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental sant: If Item 27 is marked o ပ Kim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Nam/Daughter B16 Quince Orchard Blvd., Apt T1, Gaithersburg, Maryland 20878 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or Injury or 4 Donation 5 Dother (Specify) Norbeck Memorial Park 03/23/2008 Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ie cause on each line. 23a. Part1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** days /Medical Due to (or as a consequence of): Examiner TAPHYLOCOCCI BACTEREMY Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit RECURRENT FFFUSION and Due to (or as a consequence of) Box 68760 physician pe Physician/Medical RYPTOGENIC as attending IF FEMALE for use If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9☐Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes certificate has been s rector, page 2 should Completed 24a. Was aл 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 No Division or Vital 1□ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 ပ 1 ☐ Yes 1 Inpatient 2 □ ER/Outpatient 3□ DOA After this Manner of Death Date of Injury 28b. Time of Hospital or Attending Pi 4 hours after death. Funeral Director: After t tely filled in by the funera 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 ☐ Accident (Month, Day Year) Injury М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Com , Mo DOO 65830

State Registrar

MAR 2.4 200

31. Date filed (Month, Day, Year)

JAMIE



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORANO

MO 9901 MEDICAL CENTER DRIVE
Signature

P.O. Box 68760

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records,

the Hospital

To the nosporation 24 hours after death.

To the Funeral Director: Af Medical

State Registrar HEMA P. YADLA, M.D. 9470 ANNAPOLIS ROAD SUITE 315 LANHAM, MD 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

21883

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

08

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 12, 2008 4c. County of Death Brown /Medical March 5:20P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Side
It Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Anne Arundel 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Director 305**-**48-7449 6.3 Dec.6,1944 Indiana Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County items 23a or 28a-f show Iner must be notified at 10d. Inside City Limits 1⊈Yes 2 No Director Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5249 Al 20764 Funeral Jones Drive, PO Box 88 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ⊆ ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced "natural", Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>Clinical Social Worker</u> Government is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be <u> Herman Brown</u> <u>Ernestine</u> _Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) band 5249 Al Jones Drive, Shady Side, Md Date 20764 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai PO Box 88 Wellington T. Pitts/husband 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crematory 4 □ Donation 5 □ Other (Specify) Riverdale, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee Edwards 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ER/Outpatient 3 DOA ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Pescribe how injury occurred Certification: 1 Xillatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours a

State Registrar

Bestagte Road # 300, Amapolis, MD 2140/ MD, 900 Werner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- MD

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
MAR 2 0 2008

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** 9:48A M MAUDELLA PAYNE MARCH 17 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, FEB. 13, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛣 F 1946 62 219-46-1172 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r 28a-f show notified at 1**X**Yes 2 □ No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ural", or items 23a or Examiner must be 21702 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must bonce. 1703 Rosemont Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Materials Handler Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carlton Siers Jean Florene Wolfe James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1703 Rosemont Ave. / Frederick, Maryland 21702 Terry Franklin / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cem. 03/22/2008 | Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signat of Funeral Service Licensee 21702 1621 Opossumtown Pike/ Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Syndrome Myclody splastic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and leading to many leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 21110 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 4 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 17 2008 D005 2950 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LaMont C. Smith, MD / 400 West 7th St./ Frederick, Maryland 21701

32. Regist 31. Date filed (Month, Day, Year) MAR 2 5 2008 > POLAR

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryiano		artment of F rtificate of		na wen		jiene leg. No	2000	11209
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В	Funeral		,	Sex 7. Ago 1 ☐ M 2 🕱 F		ast birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Date of Birth Month, Day	, Year)	Cou	place (State or Foreign intry)
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	r 28a	Director	10e. Street and Number		10014	шота	10f. Zip Code			1	10g. Cit	tizen of What Cou	intry?
	h wit		9744 Early Sprin	g Way			21046			ι	JSA		
	ems er mi	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of H	lispanic Origi an, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)		14. Race - Amer Black, White	
9	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or ttems 23a or 28a-f show event, th∗ M∗dical Examiner must be notified at		1 X Never Married 2 Married	If Yes, Give	No		1 ☐ Yes 2 🌠 No	Specify:				Specify:	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 si Department of Health an Important: If Item 27 is r any injury or other traur		21. Signature of Funeral Service Lic	Le atte	MO1	251 Be	2. Name and Addre Sing Home Everly L.	ss of Facility Crema Heckr	ation a cotte,	Servi	ce Cla	P.O. Boarksvill	x 784 e, MD 21029
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о. Ш	ie dea the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 Ø No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown			Other (specify)	,				Month	Day Year
<u>.</u>	hat thed the set by detacl	Ph)	Part II. Other significant conditions	contributing to death b	ut not resu	Itina in the u	nderlying cause giv	ven in Part I.		23e. Did to	bacco	use contribute to	the cause of death?
Vital Records, P.	Attending Physician: The law requires that the death cer rideath. ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	ed by							_	1 🗆 Y			bably 4 Unknown
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<u>></u>	hysic his co	은	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpatie		4 LI Nur	rsing Home	5 Resid	lence	6 ☐Other (Spec	eify)
ū	or Attending Physician: The last after death. Director: After this certificate has in by the funeral director, page 2.		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	Wor			Describe h	iow inju	ry occurred	
<u>S</u>	ttend death. ttor: /	cati	2 Accident investigat 3 Suicide 6 Could not	be 290 Place of init	un. At ho	mo farm et	M 1 □	Yes 2□N		Location (6	'tmat a	nd Number or Pu	ral Route Number,
Division or	i or A after o Direct	Certification:	4 ☐ Homicide determine	building, et	c. (Specify	()	reet, factory, office			City or Tow			rai noute Number,
	Hospital 24 hours s Funeral		29a. Certifier 12 CertifyIng	Physician: To the best	of my know	wledge, deal	h occurred at the ti	me, date and	d place, and	due to the	cause(s	s) and manner as	stated.
	To the Hospital or A within 24 hours after To the Funeral Directional Pirection Completely filled in bi	Medical	(Check only 2 Medical Ex	aminer: On the basis o and manner st		tion and/or ir			th occurred a				
	To the within 2 To the comple	Σ	29b. Signature and title of certifier) []			29c. Licens			4		ate signed (Month	
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0) 02		30. Name and address of person white HOLVS KOW	o completed cause of d	. 1		Print) Parlisent	Pky	Colun	whip	N	buy kino	21044
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 5	32. Registr	ar's Signa		haste						
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 📗 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard Clarence Palmer Sr. 5:30 /Medical March 22, 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year 3/29/1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⋈** M 2□ F Months Days Hours Min 088-14-2417 Yrs. New York Director 85 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 ie marked other then "neturel", or Iteme 23e or 28a-f ehow 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other then "neturel", or Items 23s or 28s-f show other treumstice event, it a Medical Examinar must be notified at Ocean Pines Maryland Worcester 1 XYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 16 Morning Mist Drive USA Be Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 (Types 2 () No
If Yes, Give Army/
Year or Dates AirCorp Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) accountant Exxon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Palmer Augusta Buehler 3/22/300 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35366 Poor House Lane, Round Hill, VA 20141 19a. Informant's Name/Relationship (Type, Print) Depertment of Health a important: if Item 27 is eny injury or other tree once. Richard C. Palmer Jr/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 3/24/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Storuture of Funeral Service Licensee 246T18WAY*Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompson 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke /Medical Due to (or as a consequence of): Examiner Bradycardia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Physician: The law requires that the death certificate be executed for use as the burial-transit Seizure Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed Prostate Concer 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 VNo Chronic Obstructive Pulmmary Disease 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Funeral (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 40064428 ymala OT and address of passon who completed cause of death (Item 23a) (Type, Print) NA Szymala DO -Atlantic General Hospital 9733 Healthway Drive Derlin, MD 21811 32. F. gistrar's Signature Registrar

3/29/1922

145-41-380

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For	State of Ma	ryland /				/lental Hy	giene	11211
		1	 State Registrar Decedent's Name (First, Middle, La 	st)		Cer	tificate of	Death	2. Date of De	Reg. No:	3. Time of Death/
Pĥys /Me	iciar dica	١.	Charles S. Roc						Month	Day/5 Oak	3 1010 m
Exan		4	a. Facility Name (If not institution, giv	e street and number)			//	r Location of Death		4c. County of Dea	
Funer		5	Washington Adv Social Security Number 6. S	entist He ex 7. Age ¼M 2□F	ospita (In yrs. last b 80	al irthday) Yrs.	Takoma If Under 1 Year Months Days	Park If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year) C	thplace (Ŝtate or Foreign ountry)
Directo) I		16-20-5371 Jsual Residence of Decedent						Aug.5,		ryland
arylan show	Ι,		0a. State 10b. County		10c. City, Tov	wn or Lo	cation				10d. Inside City Limits 1 ★ Yes 2 □ No
the M.	400	ן מנו	Md PG Oe. Street and Number		Ten	nple	Hills 10f. Zip Code			10g. Citizen of What C	
death with the Maryland ms 23a or 28a-f show rmust be notified at	Discotor Discotor	2	3513 Riviera S	treet			207	748		United St	-
r deatl ams 2	100	1	1. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Race - Am Black, Whi	
ITIG X IX IS-UUSO be filed within 72 hours after death with the Marylan tala Hyglene. d other than "natural", or Itams 23a or 28a-f show event, Its Medical Examinar must be notified at	Ž	2	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	1974		l□Yes 2 / ☑No	Specify:		Specify: Bl	ack
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Mar d 2 sh th and th and 17 Is m treum			19a. Informant's Name/Relationship (351	3 Rivie	ra Stre	et	er, City or Town, State,	Zip Code)
re, Maryle s 1 and 2 should f Health and Mer item 27 Is marke othar traumatic		_	Thelma Rogers/ Oa. Method of Disposition		20b. Place	Tem of Dispo	elle Hill ention (Name of	ls, Md.	20748 Date	20c. Location - City o	r Town, State
0 0 = 5			1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State y)				Cem. 4/		Arlingto	n, VA
Dallimo permit. Page Department of Important: If any Injury or	ğ		21. Signature of Funeral Service Lice	1500		22	. Name and Addre	ess of Facility Ho	dges &	Edwards	
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od sit		ē :	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as	a consequence	9 01).	otan	o II da	00/1	/	
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Page T	1	_ د	Congostry	Haart 7	aile	m.				ormed? death? 2 PNo 1 □ Ye	s 21210
OT VICAL P Physician: Th this certificate al director, pag	0	0 2	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ADER/O	D., 4	nt 3□ DOA Ott	26. Place of Dea		one) idence 6 □Other (Sp	aniful
	F	10	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day	y 28b	. Time of Injury	28c. Inju	ry at rk?		how injury occurred	өспуу
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a Hospital or 24 hours afti a Funaral Dii letely filled in			(Check only 2 Medical Exa	miner: On the basis of	examination a	and/or in	vestigation, in my	ppinion, death occu	rred at the time.	cause(s) and manner a date and place, and du	e to the cause(s)
To tha h within 24 To tha f		2	29b. Signature and title of continer	1			29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)
(E)							141	1861		3/16/0	8
212/4	1		30. Name any add ss o	completed cause of d	eath (Item 23a	(Type,	Print)	1-216	Zerk	29d. Date signed (Mor 3/16/60	20852
	State	9	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	000	all La				•
Regi			MAR 2 0 2008	Florence L	. Ans	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph Stanley Robinson lasch 6:21 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctors Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/27/1942 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**⋈** M 2□ F 65 Yrs. 577-56-4263 Wash., D.C. Director Usual Besidence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1⊟Yes 2 No Md. Director P.G. Beltsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11334 Evans Trail 20705 Funeral U.S.A.

Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0636 1 ☐ Yes 2 No Specify. Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation filed within 72 (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) 9th College (1-4or 5+) Univ. of Maryland Building Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Robinson Katie Branch Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If Item 27 Is any Injury or other trau Juanita Landis/Paramour 11334 Evans Trail, Beltsville, Maryland 20705 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Harmony Mem. Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 03/22/2008 Landover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee any 144 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer End Stage **Physician** 2 yrs /Medical Due to (or as a consequence of): Examiner ZWKS Se Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed and bunial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burie Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) spital or Attending Physic hours after death.

Ineral Director: After this ce y filled in by the funeral direct Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital on within 24 hours aff To the Funeral DI completely filled in 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARHAD JAMALI MD 7525 Greenway Ctv Dr. Greenbelt and 2077

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Robert Louis Redeen 10:00 P M March 4 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1917 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F 477-20-0589 90 13, Director June MINN Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits r 28a-f show notified at 10b. County MD 1 ☐ Yes 27 No Frederick Director Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 2 7423 Round Hill Rd. 21702 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 1 ☐ Never Married 2 ☑ Married 6 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) voice of Elementary/Secondary (0-12) College (1-4or 5+) radio broadcaster america Pages 1 and 2 should be filed in nent of Health and Mental Hygiint; if Item 27 is marked other ith and Mental Hygie 27 is marked other I r traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor Redeen Norma Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; if item 27 is any injury or other trainonce. Kira Redeen (Wife) 7423 Round Hill Rd., Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XX remation 3 ☐ Removal from State Smithsburg Crematory3/7/08 Smithsburg, MD 5 ☐ Other (Specify) 4 □ Dopation Donald B. Thompson Funeral Home P. O. Box 18, Middletown, MD 21769 2 gn Jure of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ter the disease, or complication heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death) Aspiration P
Due to or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Physician/Medical SS IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>^</u> 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No 1 ☐ Yes 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital Machifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Mortin, Day, Year) MAR 0 6 2008



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erson who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕕 🖰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 20 Day 2008ar 5:55 P M RIPPER STEPHEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ₹ M 2 □ F 189-12-6657 84 **Director** July 21, 1923 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 Yes 2 □ No Frederick Walkersville Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or Items 23a or Examiner must be a 21793 United States 251 Deer Run Drive filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Atmed Forces? 14 Yes 2 □ No WWII If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 <u>ک</u> Specify: White 3 Widowed 4 Divorced "natural" Completed Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +4 Engineering General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Stephen Ripper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 251 Deer Run Drive, Walkersville, MD 21793 Margaret Peggy Ripper / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 3/24/2008 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home our tree 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Methacilia Sensitive Stapy lucocus purvois Septiconic 15 JAW **Physician** /Medical Due to (or as a consequence of): Examiner pidural Absumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Renul Failure Division or Vital Records, P.O. Box 68760, lower lobe Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1∐ Yes 2 Mo or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes ≥No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fi investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 W. 9 Street, Free Free

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: MARHAJ Pierre MO

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month March 22, Akos G. Revesz 11:00 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 7910 Park Overlook Drive Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year,
July 25, 1 Birthplace (State or Foreign Country) 1**X** M 2 □ F 086-34-5565 1927 Hungary 80 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Bethesda Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7910 Park Overlook Drive 20817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Scientist Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Revesz Jeno Ilona Rachler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kinga Revesz/Wife 7910 Park Overlook Drive Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 03/25/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 | Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Recurrent Testicular Lymphoma 3 months Due to (or as a consequence of) Testicular Lymphoma 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **X** No Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March 24, 2008

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Director MD

Funeral

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Completed

Be

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Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

and bunal-tra physician the attending | for use as the detached ģ signed I been : has page 2

Physician/Medical

by

Be

P

Certification:

Medical

3 ☐ Suicide

29a. Certifier

29b. Sign

4 Homicide

this certificate

The law requires that the death certificate be executed or Vital Records, P.O. Box 68760, Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Division

State

31. Date filed (Month, Day, Year) MAR 2 5 2008

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Pushkas, M.D. 11510 Old Georgetown Rd. Rockville, MD 20852

32. Refistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

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dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 98/8 4-15-08 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** MARY RUTA 2008 2.4 5:30 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Nursing & Rehab Center Berlin 5. 101 Security Number If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 👿 F 81 102-20-6463 6/17/1926 Lavitia Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Worcester Ocean Pines 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21811 51 Teal Circle USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 20 Married Ruta, MAry Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Real Estate Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Greten Malvinia Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Ruta / husband 51 Teal Circle, Ocean Pines, MD: 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3/25/2008 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 22. Name and Address of Facility 21. Signature of Funeral Service Licensee The Burbage Funeral Home 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carrovorculer Euro **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 certificate has 2□ No 1 Tyes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes No 🏻 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Certification: the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

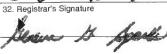
■ Funeral Director: Apletely filled in by the fi death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation in my actions of the cause (s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu 0 0 certal Highery Turote Faled, Degger who completed cause of death (Item 23a) (Type, Print) BA 5

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year March 20, 9:10p **Physician** Julio Cesar Ricardo /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) Montgomery Hospice - Casey House
5. Social Security Number | 6. Sex | 7. Age (In yrs. late Montgomery Rockville
If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) last birthday) **Funeral** Hours Days 1 M 2 □ F 92 Cuba Director 267-21-0468 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show 1 ☐ Yes 2 X No r 28a-f sh Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number o e 20903 USA 9621 Braddock Road items 23a by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Affiled Folces: 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married NO Specify: Specify: White "natural", or Cuban 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) r than " Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Pharmacist 5+7 is marked other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Digna Rosa Baras Julio Estevan Ricardo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau 9621 Braddock Road, Silver Spring, MD 20903 Berta A. Ricardo/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition March 25 1

Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Prostate Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trait Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 21 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospice Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 🗌 Inpatient 1 Yes 2 No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1X Natural 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide

P.O. Box 68760. or Attending Physician: The law requires that the death certificate be Division or Vital Records,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

this After within 24 hours after death To the Funeral Director:

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) and title of certifie 29b. Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, Md

6001 Muncaster Mill Road, Rockville, mD 20855

D64615

March 21, 2008

State Registrar

Medical

31. Date filed (Month, Day, Year, MAR 24 2008





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2256AM 2008 JANICE M. STATEN arch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM 8. Date of Birth (Month, Day, Y JUNE 25, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Months 1 □ M 2 □ XF MARYLAND 1947 60 216-48-9614 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified Director PRINCE GEORGES UPPER MARLBORO MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20774 USA 1 CAMERON GROVE BLVD., APT.#207 Funeral 14, Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed withi and Mental Hygiene. GOVERNMENT 12TH SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELSIE MAE BRYAN JAMES R. BROOKS P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health 11405 HONEYSUCKLE CT. UPPER MARLBORO, MD 20774 JOHN STATEN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages Department of Important: If it any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEMORIAL PARK03/19/2008 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility J.B. JERKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hronic Myelogonous Physician /Medical Due (or as a consequence of): Examiner St. usefully list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha performe Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 1 24 hours after death. Pe Funeral Director: A sletely filled in by the fu 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2. To the I complet and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar mar gare +

X 7

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

oan

MAD 31528

en, mi), 6128 Landover Rd., Cheverly, mi), 20785

03-14-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** Parker Spear Sadie 1650 hrs₩ March 11, "/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carrol1 Westminister Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1916 9. Birthplace (State or Foreign Couptry) December 21, North Carolina 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2XF Hours 91 Yrs. 245-10-7447 Director Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits show ral", or Items 23a or 28a-f shov Examiner must be notified at 1XYes 2 No Washington District of Columbia Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20002 United States 324 - 16th Street, N. E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify: þ 3 X Widowed 4 ☐ Divorced 'natural", al Hygiene. I other than "natura went, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Registered Nurse Hospitals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 Is marked of traumatic ever E11a **Medley** Thomas Parker ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trau Todd Vincent Fisher(Grand Nephew) 324 - 16th Street, N.E.; Washington, D.C. 20002 March 19,2008 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory, Inc. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee me and Address of Facility N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each it e. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emento ears /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or Injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s performe 2 No 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient this 28a. Date of Injury (Month, Day 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation

The law requires that the death certificate be executed Box 68760, o Division or Vital Records, P. or Attending Physician: funeral director.

2 Accident

death with the Maryland

filed within 72 hours after

pe

Pages 1 and 2 should

Maryland 21215-0036

Baltimore,

Certification: To To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

29d. Date signed (Month, Dav. Year)

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician $3:27 P^{N}$ 2008 Sandra Jean Snow March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 9011 Water Street Road Frederick Walkersville 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Days Hours MaryTand 215-36-9375 68 June 8 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County r 28a-f show notified at 1 ☐ Yes 2X No Maryland Frederick Walkersville Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ?7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be re 21793 9011 Water Street Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health Care permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Candice Nettenberg James Hatfield 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9011 Water Street Rd. Walkersville, MD 21793 Charles T. Snow / Husband March 6 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Resthaven Crematory 2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera, S Resthavens Fameral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Weeks 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final Respiratory Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 32 months Metastatic Colo-rectal Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dius to (or sella noneaguance of): Examiner certificate be executed burial-tran and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Year Por Month Day 5 Other (specify) Division or Vital Records, P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2⅓No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient P 28a. Date of Injury (Month, Day Year) Prospital or Attending Prospital of the Hours after death.

Funeral Director: After the Prospital Director of the House of Table of the House of Table of Ta in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jan 18

Kanan Hudhud, M.D. 46 B Thomas Johnson Drive, Frederick, MD 21702

32. Pagistrar's Signature

29c. License number

D 41866

29d. Date signed (Month, Day, Year)

March 5, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3 Day Month March **Physician** 2008 Elizabeth Vernon Settle Thren 4:45 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🐼 F 224-01-4064 91 Sept. 2, 1916 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 No Director Frederick Maryland | Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 United States 800 Young Place Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White þ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Seamstress/Tailor Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nelson M. Whitbeck Josie Martin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important; If item 27 Is any injury or other trau 800 Young P1. Frederick, MD 21702 Hazel R. Settle / Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, cramatory or other place) March 6 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify, Memorial Gardens 2008 Frederick, Maryland 21. Signature of Service Lice Resthaven Puteral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in only one cause on each line. 23a. Part. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician YCARS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No for 4□Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

MAR 0 6 2008

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State Registrar

DHMH 17 Rev 1/2001

			For State Registra AMEND#10enMD, 3	State of M 3-28-08, EMW.			artment			and Me		giene Reg. No.	A HILLIN	112	22
П			1 - State Registra AMEND#1perMD, 3-28-08, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) LISA MARIE SAKLAD								2. Date of Dea	ath		3. Time of D	eath
*	Physician Lica M Saklad									Month March	Day 18	Year 2008	1947	M	
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by	Funeral		Social Security Number 6.	Sex 7. A	ge (In yrs. i	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da)	h V Voar	9. Bir	thplace (State or I	Foreign
ь	Director		215-13-0102	1□M 2⊠F	22	Yrs.	Months	Days	Hours	Min.	November			iatemala	
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Maryland	d be ental ced o	o Be		nknown								Unkno	wn.		
Z	shoul nd Me mark	은	19a, Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	and Numbe	er or Rurai			Town, State,	Zip Code)	
\mathbf{z}	nd 2 s Ith ar 27 Is 1 trau		Brina Saklad - Ad	onted Mother			_						land 208		
<u>a</u>	tem tem		20a. Method of Disposition	oped nome	20b. P	lace of Dispo	sition (Nan	ne of	i		ate		cation - City or		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natu any Injury or other traumatic event, the Medical once.		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special		e Pa;	emetery, <i>cr</i> ei rklawn M Menorah	natory or o lemoria	<i>tner piac</i> 11 Par	ek &	03/21	/2009	Doole	110 M	owrland	
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Вох	ndin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy								2	3d. Date of de	livery		
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r <	Physician: r this certifica ral director, I	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ⊠ Inpa	tient 2	ER/Outpatier	nt 3 DC	Othe	er: 4 □ Nu	ırsing Hon	ne 5 🗆 Resid	dence 6	Other (Spe	ecify)	
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	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	and manner					e number						
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			30. Name and address of person who		,				14		2007.0				
			Amy Woitach, D.O., 31. Date filed (Month, Day, Year)		Glen R strar's Signa		ıver Sp	oring	, Mary	rand 2	70910			· · · · · ·	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene UUS Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** STINSON MARCH 3008 LIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL CITY BALTIMORE Johns Hopkins Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 □ F Days Hours Director 166-54-7342 PENNSYLVANIA JUNE 8,1969 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 1 □Yes 2 No Director SUSSEX LEWES DELAWARE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 BEEBE DRIVE, BEEBE FARMS 19958 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married SpecifyHITE 1 ☐ Yes 2 🛣 No altimore, Maryland 21215-0036 Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GRAIN CFERATOR POULTRY FARMS Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis
WILLIAM FRANCES STINSON ALICE ANN HORNE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERYL M. STINSON/WIFE 16 BEEBE DRIVE, BEEBE FARMS, LEWES, DE 19958 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) EASTERN SHORE CREMATORIUM 03/25/08 LEWES, DELAWARE 21. Signature of Fameral Service License M00866 22. Name and Address of Facility

PARSELL FUNERAL HOMES & CREMATORIUM 16961 KINGS HIGHWAY, LEWES, DELAWARE 19958 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HYPOTENSION /Medical Due to (or as a consequence of): **Examiner** BLEEDING 10 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner LUPUS The law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed? Yes 2 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

JOHNS HOKENS HOSPITAL. 600 N. WOLFE STREET BALTIMORE.

MARCH 20 , 2008

21287

DRAWARIAN MEDICAL DOCTOR

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RANGACHARI

MAR 2 4 2008

31. Date filed (Month, Day, Year)

Due to (or as a consequence of)

xaminer

or condition resulting in death)

Sequentially list conditions,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed Be Certification:

Medical

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

APR 0 7

if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last X AMENDED 23a,2/,28a-1, perME, g881 //1//08 TT #23a,27,per ME,g879 5/14/08 TT XUNPENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 X No Pending Fnd 3/31/08 Fnd 1:05 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Rural Route Number, City F1 or Town, State) 13502 Crossover Rd 3 Suicide Could not be residence (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

O.C.M.E.

OCME

111 Penn Street, Baltimore, MD 21201

1332 hrs

1 Yes 2 X No

Approximate Interval

Death

29d. Date signed (Month, Day, Year)

April 1, 2008

een Onset and

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

Jn,

32. Registrar's Signature

Assistant Medical Examiner

Name and address of person who completed faulle of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death Month Day March 13, 2008 Medical Examiner 1935 hrs SARAH YABODE TACKIE 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Prince George's **Doctors Community Hospital** Lanham 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director CountryGhana 213-15-9882 2 X F 60 06-15-1947 1 M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 X No Prince George's Lanham death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 7029 Woodstream Lane 20706 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 x Married 2 X No Yes Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Black Divorced Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 1+ Carlson Travel Agency Travel Agent 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Akiwumi Mercy Quartey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerita Ahia 9983Goodluck Road #202 Lanham, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date unk 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 X Removal from State Accra, Ghana OSU Cemetery Other Specify. Donation 5 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of June Service Licensee 4308 Suitland Road, Suitland, MD 20746 Approximate Interval or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cay /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that Initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760. IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of certificate has be ector, page 2 sh death? performed? ✓ Yes 2 ✓ Yes 2 No e Hospital or Attending Physician: 124 hours after death. 5 Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Other4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural Yes 2 No Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 14, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 MAR 2 0 Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

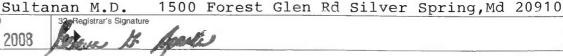
> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



29b. Signature and title of certifier

Ghousia

29c. License number

D56691

29d. Date signed (Month, Day, Year)

March 16,2008

08-01725 Dar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

niel Woods		State of Maryland / Department of Certificate of Registrar		nd Mental Hy		a. No. 200	8 1122				
Physicia	an/	Daniel Woods			Date of Death Month	Day Year	3. Time of Death 1302 hrs				
edical Exami ∖₄	ner		4b. City. Town.	or Location of Death	February 29	9, 2008 4c. County of Deat					
		104 Abbott Court Walkersville Frederick									
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye		s. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or						
Director		$570-11-3266$ 1 \times M 2 $-$ F 43 Yrs		ays Tiours IVIII.	05/13/1964 Foreign New Country York						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion				10d. Inside City Limits				
Maryland 28a-f show any d at once.	ō	Maryland Frederick Walkersv	ille				1 X Yes 2 No				
Maryll r 28a-f	Director	10e. Street and Number 104 Abbott Court	10f. Zip Code 2179		10	g. Citizen of What Cou					
death with the Maryland or items 23a or 28a-f sho must be notified at once.				Hispanic Origin? (Sp	pecify Ves or No-	United S	ican Indian, Black,				
leath w r items	Funeral	1 Never Married 2 X Married Armed Forces? If Y	White, etc.	rount morally places,							
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036 ithin 7 me. r than	Completed	5+ Submissions Specialist Pharmace									
Baltimore, MD 21215-0036 germit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at one.		17. Father's Name (First, Middle, Last) Richard Woods		18.Mother's Name	e (First, Middle, M Walsh	laiden Surname)					
212 Auld be Menta marke	lo Be		g Address (Str			ber, City or Town, Stat	e, Zip Code)				
MD d 2 shc Ith and n 27 is	- 1	· · · · · · · · · · · · · · · · · · ·				11e, MD 2					
Baltimore, MD remit. Pages 1 and 2 sho Department of Health and Important: If item 27 is nightly or other traumating or other traumating.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition crematory or of			rch 2,	20c. Location - City o	r Town, State				
ltim it. Pag rtment rtant: y or of	74	4 Donation 5 Other Specify: Resthave 21. Signature of Euror Service Usensee 22.	n Crema	$_{ m atorv}$ 2	008	Frederic	k, Maryland				
Balti permit. Departm Imports injury o	0.00	Rec. 95	sthave 01 Cato	n Funera octin Mtr	l Servi	ces, Skko Frederic	ot Cody P. A k ,MD 21701				
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/Medical Examiner		Immediate Cause (Final Lease or condition resulting in death) Due to (or as a consequence of):					Death				
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id sit	xan	events resulting in death) Last Due to (or as a consequence of):									
Sox 68760, death certificate be executed to attending physician and if for use as the burial - transit	edical I	d. UNPENDED AMENDED			·-· ·						
760, cate be ex physician he burial		IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of delive	ry				
Box 6876 e death certificate the attending phy ed for use as the	cian/	past 12 months?	etal death ther (Specify)	3 Ectopic pregna	ancy	Month	Day Year				
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Vita hysicia this ce	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien				Residence 6 🗸 Oth	er: Scene				
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risio r Atter er deat irector	ficati	2 Accident Investigation Feb 29, 2008 1245 hrs 3 ✓ Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre					ural Route Number, City				
Div	Certification:	4 Homicide determined (Specify) Townhouse / Rowhou	se		or Town, St 104 Abbott Co	tate) ourt, Walkersville, M	D				
Division of Vita To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this cer completely filled in by the funeral direct		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigations.									
To t Voith	Medical	and manner stated. 29b. Signature and title of certifier		ense number		29d. Date signed (M					
		10 Analy Desiro	0.0	C.M.E.		March 1, 2008					
5		30. Name and address of person who completed cause of death (Item 23a)	. 01	No. of the case	204						
	tate	Laron Locke MD. Assistant Medical Examiner 111 Peni 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	o Street, Bal	timore, MD 212	201		·············				
Regis		MAR 0 6 2008									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 17, 2008 8:40 pM Ira Bailey Westfall March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carrol1 Dove House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | NoV. | 5, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F 48 Months West Virginia 216-74-3589 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1X Yes 2 No Director Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 82 Kenan Street 21787 United States by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates Completed and Mental Hygiene.

Is marked other than "nature aumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction worker construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Bibe Juanita Biller ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 la Annette M. Westfall - wife 82 Kenan Street Taneytown, Maryland 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot March 19. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10/07-3/19/08 **Physician** Metastatic Carcinona of Kidn /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown After this certificate has been signed by i funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mo 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Definer (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospu 5 Pending investigation To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number WJL

Registrar DHMH 17 Rev 1/2001

State

10

30. Name and address of person who completed cause of

31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Dep State Ce	artment of Health and N ertificate of Death	lental Hygie Reg.	4000	11229
			Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death	
	hysicia /Medic		Fulah Grace Wilson	March 19	Day Year 7 2008	1:30a ^M	
	Examin	1 1	4a. Facility Name (If not institution, give street and number)		4c. County of Death		
-9/4	(S)	1.3	Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Takoma Park) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		ntgomery place (State or Foreign
	ineral rector		578-46-9167 1□ M 2€XF 86 Yrs.	Months Days Hours Min.	(Month, Day, Ye	1921 West	intry)
yland	at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
Mar	a-fsh iffied	ctor	Maryland Prince George's	Hyattsville			1 ☐ Yes 2 ☐XNo
#	or 28 e not	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
ath w	23a ust b		8210 18th Avenue	20783		USA	
U Z IZ I S-0030 filed within 72 hours after death with the Maryland Hygiene.	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
S hou	atura cal E		15. Decedent's Education 16a. Dece	edent's Usual Occupation	16	l b. Kind of Business/l	
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be file	d oth event	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	,	
Mer Mer	narke natic	2	Pendleton Lawrence		nia Susan		
e, Mar yland 21218 1 and 2 should be filed within Health and Mental Hygiene.	er traun		19a. Informant's Name/Relationship (Type. Print) 19b. Mail Virginia Susan Einfeldt/Daughter	ing Address (Street and Number or Rur 8210 18th Avenue,			, ,
			I bunal 2 ki Cremation 3 Hemoval from State	ematory or other place) Mar	Cn 23	c. Location - City or	
permit. Page Department of	oortan Injury Se,	Ì	21. Signature of Funeral Service Licensee	22. Name and Address of Facility		exandria,	Virginia
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/Me	sician edical miner		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consumption of the condition of the	Ther the mode of dying, such as cardiac	or respiratory arrest	, 	Approximate Interval Between Onset and Death
icate be executed	been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):				
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.	the attending p thed for use as t	Physician/Mec		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
quires that t	n signed by	۵	Part II. Other significant conditions contributing to death but not resulting in the		the cause of death?		
The law rec	After this certificate has bee funeral director, page 2 shou	Completed			24a. Was an autopsy pertorme	prior to d	topsy findings available completion of cause of
cian	ector,	Be	25. Was case referred to medical examiner?		h (Check only one)		
Physi	this g	은	1 Tes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time			e 6 □Other (Spec	cify)
ath.	nr: After	ation:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	injury occurred	
tal or Atte	To the Funeral Director: Aff completely filled in by the fur	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
he Hospi in 24 hour	he Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	and due to the caus rred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)	
or with	Con	Σ	29b. Signature and title of certifier	29c. License number	17 290	Date signed (Month	n, Day, Year)
)			30. Name and address of person who completed cause of death (Item 23a) (Type Nasreen Kango, MD 7610 Carroll Av	Print) enue, Takoma Park,	MD 20912	2	
F	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 4 2008 32 registrar's Signature	antes			

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				State of Marylan			ealth and M		•	J.
			1 - For State Registra MEND#23a(I+II,	nerMD3-24-08 PMW	M~Cer	tificate of I	Death		eg. No.	8 11230
			Decedent's Name (First, Middle, Last		, MUCO	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Deat	h	3. Time of Death
	Physic /Medi		YUEH-HENG Y	ANG				Month O3	18 26	8 12159 PM
	Exami		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of [
				JENERAL HO	SPITAL	- OLNE	Y, MD		MONTG	SMERY
П	Funeral Director		5. Social Security Number 6. Se 545-96-1550	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					01 11	MAI	MINN
	anylan show	_	10a. State 10b. County		ty, Town or Loc	ation				10d. Inside City Limits
	Ba-f	cto	MD Montgo	mery):	(NE2	Sprin	9			1 Yes 2 No
	filed within 72 hours after death with the Maryland Hygiene. thar than "netural", or ftema 23a or 28a-f show int, the Medical Examinar must be notitied at	Funeral Director	10e. Street and Number 3200 N. LEISURE	WORLD BLVD	#818	10f. Zip Code 209.0	<i>C</i>	1	Og. Cilizen of Wha	(Country?
	heath	era	11. Marital Status	12. Was Decedent Ever in U.			Y	acify Yes or No-	USA 14 Baces	American Indian,
9	after o	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No			spanic Origin? (Spo n, Mexican, Puerto	Rican, etc.)	Black, V	Vhite, etc.
93	iral',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐Yes 2XNo	Specify:		Specify: A	BIAN
215-0036	n 72 h	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Decede (Give k	ent's Usual Occupa	ation fu <i>ring</i> most of works)	ing	16b. Kind of Busin	ess/Industry
212	withir ene. than	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)		LTURAL	ECONOM	15T R	ESEARCH	INSTITUTION
	filed Hygir other	ပိ	17. Father's Name (First, Middle, Last)	/ 1	76,710		18. Mother's Name			014711100110014
lan	ald be dental rked o	To Be	DE-CHING YANG	6			5H14-61	TENG (Hu	
Maryland	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any rigury or other fraumatic event, the Mones.		19a. Informant's Name/Relationship (Ty	rpe, Print)			and Number or Rura	A Route Number	City or Town, Sta	
	1 and 2 Health em 27		ANDREW YANG / G	DN			ook cou	RT, LUT	HERVILLE	MD 21093
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F		lace of Dispos emetery, cremi	ition (Name of atory or other place		Date	20c. Location - City	or Town, Slete
ţ	permit. Pag Department Important: I any injury c		`4 ☐ Donation 5 ☐ Other (Specify)	110	se H	:115 Men	1. 3/2	7/08/	Vhi +tie	er, CA
Bal	permit. Departr Import. any inj		21. Signature of Funeral Service License	90 K		Name and Addres		-	ler's So	-
· es	2		23a. Part1. Enter the disease, or compli	ications that caused the death	h. Do not enter	the mode of dvino	nsin Ave.	N.W. W	ashington	D.C. 20016
	Physician		Immediate Cause (Final	ne cause on each line.	C		,, 00011 000 001 0100 0	. roopilatory arre	, , , ,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequ	uence of):					
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	p #	ner	Sequentially list conditions, if any, leading to immediate cause Finds inderlying. Due to (or as il consequence of):							
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60,	ite be ex iysician ne burial	cal E		Due to (or as a consequ	uence or):					
68760	9 4	dic		1.						
Box (leath certificat attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of	delivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		ctopic pregnancy Other (specify)			Month	Day Year
P.0	that the de led by the detached	hys	9 Unknown	9□ Unknown						
	90	by	Part II. Other significant conditions con		ulting in the und	lerlying cause give	n in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
ord	w requir been si should	ted	Amnythmia					1 🗆 Ye	s 2 No 3	Probably 4 MUnknown
Records,	has b	ompieted	Urinary	retention				24a. Was ar autopsy	orior	autopsy findings available to completion of cause of
a F	Thate page	O	Heart fo	wilve Milti	-Infarct	Dementia		perform 1 Yes 2		1? ∕es 2□ No
× ×		o Be	25. Was case referred to medical examiner?	lospital:		3 DOA Other	26. Place of Death			
o	p Phys ar this aral di	\vdash	1 ☐ Yes 2 ☐ No ☐ ☐ 27. Manner of Death	1 Inpatient 2 I	ER/Outpatient 28b. Time of	3 DOA 28c. Injury	4 Norsing Hor	ne 5 🗌 Resider 28d. Describe ho	nce 6 Other (S	pecify)
ion	Attending Ph r death. ector: After thi by the funeral	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work'			,,	
Division of Vital	or Attendater death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stree	t, factory, office	2	28f. Location (Street and Number or Rural Route Number,		
	rs after at Dire	Cer						City or Town,		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati	wledge, death o	occurred at the time	e, date and place, a	and due to the ca	use(s) and manner	as stated.
	To the Vithin 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License				
)	V With		A CONTROL OF CONTROL						d. Date signed (Mo	
-	5	+	30. Name and address of person who col	moleted cause of death /ltom	23a) /Tupo B-		56132		3/18/200	0
			Narita Surar	- n - n -			MORSE	DR. CO	LUMBIA	MD 21045
	Sta		31. Date filed (Month, Day, Year)	32 registrar's Signat		150				1 6:050
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Physician HDA th 10:20AM 5 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ARBOR BALTIMORE If Under 1 Year | If Under 24 Hrs. HOSPITAL 8. Date of Birth 9. Birthplace (St. (Month, Day, Year) 9. Birthplace (St. Country) July 23, 1922 Maryland Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 💢 F Hours 85 218-18-7357 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show t be notified at show 1 □Yes 2X No MD Baltimore Director Baltimore Highlands 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hyglene. Important: If ifen Z7 is marked other than "natural", or items 23a. any Injury or other thaumatic event, the Medical Examiner must b 2823 Michigan Avenue 21227 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emil Hartman Anna Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Adams/Husband 2823 Michigan Avenue Baltimore MD 21227 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State MD Veteran Cemetery @ 04-08-2008 Garrison Forest Burial 2 □ Cremation 3 □ Removal from State Owings Mills, Maryland 4 Dopation 5 D Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signatura of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke Physician /Medical Due to (or as a consequence of): **Examiner** locardia Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as # nonsequence of) Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): ng physician a Box 68760, Physician/Medical signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 1 🗌 Yes 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 2 - No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Matural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director; At completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registra

29b. Signature and title of certifier

2

APR 0 8 2008

31. Date filed (Month, Day, Year)

Baltimore 5 + Y88+ 32. Registrar's Signature

tawossen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

2/225

29d. Date signed (Month, Dav. Year)

Registrar

State

EDWARDS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 11:40PM 41 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 3323 Alto Road n/a Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Yrs Director <u> 248-44-1176</u> 80 **2/8/192**8 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene.

The marked other than "natural", or items 23a or 28a-f show other than "matural", or items 23a or 28a-f show other than the traumatic event, its "Medical Exert in the property." 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Widden Evander of the by north of at Funeral Director 1X Yes 2 ☐ No n/a Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3323 Alto Road 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Specify: African-American ☐Yes 2 No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pipe Laborer Deneau 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Anderson Annie Wilson ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Anderson/Wife 3323 Alto Road, Baltimore, MD 21216 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition. Pages 1 ment of H ant: If ite ury or ot permit. Page Department of Important: If any Injury or 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) King Memorial Park 4-9-08 Woodlawn, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licensee 9200 LibertyRoad, Randallstown, MD 21133 23a. P. 11. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of l or Attending Physician: The law requires that the death certificate be executed after death. the burial-transi resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 2 🗌 No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Sesidence 6 ☐ Other (Specify, Manner of Leath
Natural
Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 □ Yes 2 \square No Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral Di ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal completely (Check only and manner stated.

K State Registrar 29b. Signature and title of tertified

ess of person who completed cause of death (Item 20a) (Type

trar's Signature

29d. Date signed (Mon.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 5:00 Bacon 2008 nomas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ltimore 5. Social Security Number Poin Mursina + Reileame If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 12 M 2□ F 19-36-0438 Director Masy Jano 19-1941 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Examiner must be retified at once. 1- Yes 2 □ No Director MD IMC) (e more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USP Floor Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: While 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Output

Description: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Acines Thomas J Racon Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) 3310 MO 21221 Barbara 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location -City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HUCLSON mD. 21220 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CAPDIOVASCULAR DISEASE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transit T E Box 68760. attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 C Ectopic pregnancy ρ in the past 12 months? Month Year Day 5 Other (specify) P.O. 1 □Yes 2 □No 9 Unknown à s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of pause of death? cate has b page 2 sl 24a. Was an perform certificate I 2 1 ☐ Yes 1 ☐ Yes 25. Was case referred to predical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1∐ Yes this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28b. Time of Injury 27. Manne f Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending atural 5 Pending investigation 1 ☐Yes 2 No death. neral Director: / Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State

Registrar

APR 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 April 2, **Physician** 2:24PM M Branciforte Agnes Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 21, 1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mary Land 1□ M 2□ F 84 215-12-5074 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No in and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, I'm Modical Evaminer must be notified Director Baltimore Essex MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with U.S.A. 21221 957 Thompson Blvd. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Mary Ann Postanowicz George Szczepaniak ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health an ant: If item 27 is I 1887 Amanda Lane Finksburg, Maryland 21048 Mrs. Regina Karwacki/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Gardens of Faith Cem: 4/7/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck F.H. of Prindalk, 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC CANCER OF UNKNOWN NENTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical signed by the attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 🔀No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown EMPHYSEMA page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 □ No 1 ☐Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1∐Yes 2∭ZÎNo Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation or Attending 1 Natural 1 □Yes 2 □No hours after death. 2 Accident Director: d in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Hospital 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 2, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NONAPLES ST, SUITE 209 BATTMORE, MS 21204 DANIEUT DOBETMAN, MO 31. Date filed (Month State Registrar

4/2/08

Stancitorte,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 008 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Michael G'OUR M 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parks, 14 Markino Balhane Genie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Days Yrs. Dec.21, 1952 Maryland 216-58-2687 55 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Front Royal VA Warren Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 22630 107 W. 13th Street Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Machinery other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madeline Hicks Joseph S. Bena 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau 107 W. 13th Street Front Royal, Virginia 22630 Lori Blesi/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4/7/08 Towson, Maryland 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Closed Theat **Physician** Due to r as a consequence of): 3mm4s disease or condition resulting in death) /Medical 3 mm Hi, Examiner Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed that initiated events resulting in death) Last and as the burial-trar Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic preg jo in the past 12 months? Day 5 Other (specify) 1□Yes 2□No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? tracheiros 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Ford . 1914 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Injury 1 □ Natural 5 Pending investigation on Hoor of suns bedroca an 4 200 6 unlens-To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur 1 Yes 2 Ho 2 Accident 6 Could not be 8e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

Division or Vital Records.

State

31. Date filed (Month) Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who

100002

completed cause of death (Item 23a) (Type, Print)

6701 N Charles St Site 4202

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

W. 13 #4 57

29d. Date signed (Month, Day, Year)

3

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Aprili 7, 2008 Michael John Bondyra 2:10 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview Nursing Center Baltimore Essex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** September 30, 1921 Poland Hours Days 217-30-3318 1 M 2 □ F 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 ☐ No Maryland Baltimore nit. Pages 1 and 2 should be filed within 72 hours after death with the Mar attrinent of Health and Mental Hygiene. ortant: If lean Z7 is marked other than "natural", or items 23a or 28a-f shiplup or other traumatic event, the Medical Examiner must be notified. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6219 Fairdel Avenue 21206 Poland 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Mechanic Air Conditioning Company 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Bondyra Anastasia Glan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Laurel Path Court Baltimore Maryland 21236 Frances H. Ohl/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if any injury or St. Stanislaus Cemetery Baltimore Maryland 4/10/08 22. Name and Address of Facility 5305 Harrord Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee hister 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Tract Infection Examiner 1196 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on 1 ☐ Yes 2 No Other: 4M Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at / 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar APR 0 8 2008

29b. Signature and title of certifie

of death (Item 23a) (Type, Print) 24 Mace Avenue, Baltimore 32. Registrar's Signature

29c. License number

D0061907

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Sishop 200 3 11:07 DM CYIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** of Sats-Rackull Breiner Morning 3, de Horse If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year 5/30/1928 1 □ M 2 T F Hours 217-22-2684 MARYLAND Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Director BALTIMORE LOCH HILL MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21239 6671 LOCH HILL ROAD Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🟋 No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SHEPPARD PRATT ANYIETY THERAPIST YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CATHERINE HEROLD RAYMOND ANDERSON ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13510 ALLISTON DRIVE BALDWIN, MD 21013 KAREN FREW/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/9/2008 TIMONIUM, MD 21. Signature of Funeral Service Licensee 21286 TOWSON, MD 8521 LOCH RAVEN BLVD. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alzehermers 40115 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 → No 3 Probably 4 Unknown Completed C. P.15 24b. Were autopsy findings avallable prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 101hg=00 1□ Yes 2 1 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 23531-2 Cru-1 ☐ Yes 2 40 2 ☐ ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 ☐ Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 29a, Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1) 3/29-7/01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Suite 4202 21206 70ws .~ wends Klopsz 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

0 8 2008

APR

			For State Registrar	State of Marylan		rtment of H rtificate of I		nental Hyg	leg. No. 2 (008	11239		
r	100		Decedent's Name (First, Middle, Last)					2. Date of Dea	th	V	3. Time of Death		
	Physicia /Medic		Annie	E.		Bosto	n	Month O3	Day 3	2-008	7:10 PM		
	Examin	762	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of Death		4c. Count	y of Death			
			Keswick Nursing		Baltimore								
	Funeral Director		5. Social Security Number 6. Sex 217-20-6679 1□	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	9. Birthp Coun	lace (State or Foreign try)		
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	23a ust b	ral	3314 Spaulding				.215			J.S.A			
	tems term	Funeral	11. Wartar Status	Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - Americ ack, White,			
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7	Hygie ther t	ပ္ပို	17. Father's Name (First, Middle, Last)	ira	DON	ICDC1C II	18. Mother's Nam	e (First, Middle,					
0	d be ental ked o c eve	To Be	Daniel Reed				Molly	Clayto	n				
۵ کا ا	shoul Mind Mind Mind Mind Mind Mind Mind Mind	۲	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailin	ng Address (Street	and Number or Rui	ral Route Numbe	r, City or Towr	n, State, Zip	Code) 21216		
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נו כ	of Health of Health Fitem 27 rother tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. F	lace of Dispo emetery, crer	sition (Name of matory or other plac	ce)	Date	20c. Location	- City or To	own, State		
É	Pages ment of H ant: If ite ury or of		4 □ Donation 5 □ Other (Specify)	Arb	utus	Memoria	1 Park	4/8/08	Arbut	us,	Md		
משו	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service License	Dannik	M	Name and Addre	H West	Dala	imana	Ma	21215		
6			23a. Part. Enter the disease, or complic	cations that caused the deat			ash Ave			MO	Approximate Interval Between		
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	certifi Iding Ise as		IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome pf pregna	ancy				23d. D	ate of delive	erv		
אַ מכא	The law requires that the death certif site has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d]Ectopic pregnancy]Other <i>(specify)</i>	y			lonth	Day Year		
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5	Physical this call dire	은	1 163 2 1010	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier		4 Nursing H	ome 5 Resid			(y)		
2	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	injury	Wor	k? Yes 2 □ No	28d. Describe h	low injury occu	irred			
22	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	rtific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Num n, State)	nber or Rura	al Route Number,		
_	spital ours a neral			ician: To the best of my kno									
	the Ho iin 24 h the Fui ipletely	ledical	one)	ner; On the basis of examina and manner stated.	tion and/or in								
	To Corr	Σ	29b. Signature and title of certifier			29c. Licens	Doos 90 S	i i	29d. Date sign	ed (Month,	Day, Year)		
	. \		1 20	M)	- 00-\ /T		7003 70 0		2/21	100			
	4		30. Name and address of person who co	a MO 36	12 F	alls RZ	Belt	MO 2	1211				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	Par	Ro							
				.0	S. S								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylar	-	rtment of F tificate of				giene 2	008	11240
			1. Decedent's Name (First, Midd	lle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
,	Physician /Medical Norman Earman Brooks, Jr.									April			10:30P M
	Examin		4a. Facility Name (If not institution	on, give street and nu	umber)		4b. City, Town, o	or Location	of Death		4c. Cou	inty of Death	
	North Arundel Health & Rehab. Ctr.					n Bur				ne Aru			
	Funeral Director		5. Social Security Number 217–34–2386	6. Sex 1 M 2 □ F	7. Age (In yrs. 73	. last birthday)_ Yrs.	Months Days	If Under Hours	Min.	8. Date of Bird (Month, Da 08-02-		Coui	place (State or Foreign ntry) nington D.C.
	and		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Ci	ity, Town or Loc	ation					1	10d. Inside City Limits
	Maryl f sho	ō	MD Anne	Lot muse A			Oden	ton					1 □Yes 21 No
	28a- notif	rec	10e. Street and Number	e Arundel			10f. Zip Code	LOII			10g. Citizen	of What Cou	ntry?
	h with	<u>=</u>	725 Linden Gro	ove Place	Apt. 10) 1	2	1113			Unit	ed Sta	tes
	deat	Funeral Director	11. Marital Status		cedent Ever in U		as Decedent of H		igin? (Spec	cify Yes or No		Race - Americ	can Indian,
36	be filed within 72 hours after death with the Maryland ntal Hygiene. A other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 TYes	^{2□No} 19.	54 - 1	□Yes 2XINo			iloan, etc.)		Black, White, ecify:	nite
21215-0036	2 hou latura ical E	ted	15. Decede	nt's Education		16a. Decede	ent's Usual Occup	pation			16b. Kind o	of Business/In	
21	thin 7 an "r Med	Completed	Elementary/Secondary (0-12)	est grade completed, College) (1-4or 5+)	life. D	ind of work done O NOT use retire	d) auring mos	st of workin	g			
21	ed withi ygiene. ier thar t, the M	S	7			P:	rinter					ok Bir	nding
Maryland	8 - a e	Be	17. Father's Name (First, Middle	, ,				18. Mothe	er's Name	(First, Middle,	Maiden Sur	name)	
yla	ould I Men narke	입	Norman E. Br	.		T				ıy A. L			
Mar	12 sh h and 7 is n traum		19a. Informant's Name/Relation				Address (Street						,
	les 1 and 2 should be of Health and Ment fitem 27 is marked or other traumatic errother		Barbara Brooks 20a. Method of Disposition	/ Wife	20b.	725 L:		ove P		Apt. 1		nton,	MD 21113
ō	ages nt of :: If it		1 X Burial 2 ☐ Cremation		State	cemetery, crem	atory or other pla	1					,
3altimore,	nit. P. artme ortani Injury		4 Donation 5 Other (21. Signatur of Funeral Service		7 MI		ans Ceme	ess of Facili	04 - 15	-2008	Chelt	enham,	Maryland
Ba	permit. Pages 1 a Department of He- Important: If item any Injury or othe).))	Estuce	Nall	ugli		Name and Addre Donaldso: 1411 Ann	аротт	s koa	a vaen	ton, M	tory, Marylan	P.A. d 21113
ж.			23a Part1. Enter the disease, of shock, or heart failure. Lis	r complications that tonly one cause on	caused the dea each line.	th. Do not ente	r the mode of dyi	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)				ive Pulm	onary	Dise	ase			years
	/Medical Examiner		rodaling in dodainy	Due to	(or as a consec	quence of):							
E		ī.	Sequentially list conditions,	b. — Due to	or as a conse	tience of							
bu	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			,							
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		sician/Medical	IF FEMALE:										
Box	Attending Physician: The law requires that the death certific reath. ector: After this certificate has been signed by the attending cetor: by the funeral director, page 2 should be detached for use as	an/	23b. Was decedent pregnant in the past 12 months?		utcome pf pregn birth 2 ☐ Feta		Ectopic pregnanc	у			23d.	Date of delive	•
	ne dez the at hed fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of one of the second of the sec	death 5□	Other (specify) _					MOTELL	Day Year
P.0	that the de led by the detached	Phy	Part II. Other significant condit	ions contributing to	death but not res	sulting in the unc	dedving cause giv	en in Part I		23e. Did to	nhacco use o	contribute to t	he cause of death?
or Vital Records,	w requires to be some signer should be considered.	d by	Coronary Art				,g g		•	1			pably 4X]Unknown
Ö	v required	Completed	•				1-						
Re	The lar	립								24a. Was autop perfo		prior to co death?	opsy findings available impletion of cause of
<u>ra</u>	ician: The certificate		25. Was case referred to medical	al I					(5, 11	1□ Yes	2 X No	1 ☐ Yes	2 □ No
Ş	/sicia	o Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	TER/Outpatient	3 DOA Oth			<i>(Check only o</i> ne 5☐ Resid		Oth (C	£.3
ō	ding Physician: n. After this certific funeral director,	다.	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Inju			8d. Describe h			y)
0	ath. ir: Afte	atio	Z Accident	igation	nth, Day Year)	Injury		rk≀ Yes 2∐	No				
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	mined 28e. Plac	e of injury - At h ding, etc. <i>(Speci</i>	ome, farm, stre	et, factory, office		2	8f. Location (5 City or Tov	Street and Ni vn, State)	ımber or Rura	al Route Number,
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifyi (Check only 2 Medica	ing Physician: To th	e best of my kno	owledge, death	occurred at the ti	me, date ar	nd place, a	nd due to the	cause(s) and	f manner as s	stated.
	the hin 24 the F nplete	Medical	one)	and mar	nner stated.	and of file			an occurre				
	5 1 1 1 1 1 1 1 1 1 1	2	29b. Signature and title of certific	-2	Ω.		29c. Licens	se number			29d. Date si	gned (Month,	Day, Year)
		1	NVH	Jehonge				- 405	21		April	07, 2	800
	341		30. Name and address of person					1+0 0	00 01	on Desc	nd c	m 0100	1
-	Sta	te	Mahesh S. Ocha:		Registrar's Sign	ture	M. s	ile Z	OO GI	en Bur	nie, M	m 2106	0.1
ε.	Registr		APR US	2000	September 18	1	100						

DHMH 17 Rev 1/2001

		For	State o	f Marylan			lealth and N	lental Hy	giene	0.0.0	1 3 0 1 1
	1 - State Registrar Certificate of Death Reg. No. 2 0 8										11241
Physicia		1. Decedent's Name (First, Middle Richard	R. Brown	ing, IV				2. Date of Dea Month March	ath n 29, 2	2008	3. Time of Death 9:15 M
/Medic Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, o	r Location of Death		4c. Cour	nty of Death	
		6201 Darr	owberry C	ourt		G1enn	Dale		Prin	ice Ge	orge's
Funeral	1	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Yea <i>r)</i>	9. Birthp	place (State or Foreign ntry) 1nois
Director		578 06 3420	1□M 2□F XX	41	Yrs.			Aug 4,	1966_	111	inois
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
Mary f sho	to	Maryland Princ	e George		71 D	.1.					1 □ Yes 2√ No
r 28a	Director	10e. Street and Number	e George		Glen Da	10f. Zip Code			10g. Citizen	of What Cou	ntry?
h with		6201 Darrowb	erry Cour	t		2	20769		United	Stat	es
ems :	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. F	ace - Americ	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 🐧 Marr 3 ☐ Widowed 4 ☐ Divorced		2 □ No ve		1□Yes XXNo	Specify:				an American
72 hou natura dical E	Completed	15. Deceden (Specify only higher	l t's Education st grade completed)		ı (Give	dent's Usual Occup kind of work done	durina most of worl	king	16b. Kind of	Business/In	dustry
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filed v Hygie ther t		17. Father's Name (First, Middle,	4		DL.	JOI. US A	18. Mother's Nam	ne (First, Middle,			
d be i	o Be		R. Brown	ing, III	Ι			a L. Wa		,	
shoul nd M	은	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Tov	vn, State, Zij	o Code)
and 2 auth a 27 is er trau		Natasha D. Bro	wning (Wi		6201	Darrowbe	erry Cour	t, Glenr	n Dale,	MD 2	0769
es 1 a of He		20a. Method of Disposition XXBurial 2 □ Cremation	2 Domousi from	20b. P	Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)April 1	Pate 2008	20c. Locatio	n - City or T	own, State
t. Pagi tment tant: li		4 □ Donation 5 □ Other (S	pecify)		ryland	Veterans	s Cemeter	у	Chel	tenham	, MD
permir Depar Impor any Ir		21. Signature of Funeral Service	$I \subset V$	200257			ss of Facility Lee Ferry Re				6633 01d 0735
		23a. Part1. Enter the disease, or shock, or heart failure. List									Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	or as a consequ	uence of):	Neuro	endocri	ne Co	Lncel	۲. ۱	
Examiner	Examiner	Sequentially list conditions,	b. Due to	For es e ponsagi	uence offr						
nd Applied		Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
icate be executed physician and s the burial-transit		resulting in death) Last	Due to	(or as a consequ	uence of):						
ficate g phys	edical		0								
The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live	tcome pf pregna birth 2 □ Feta nant at time of d own	l death 3□	Ectopic pregnanc Other (specify)	у			Date of deliv Month	rery Day Year
w requires that the d been signed by the should be detached	by Ph	Part II. Other significant condition	ons contributing to d	eath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use c	ontribute to t	the cause of death?
equire en sig ould b								1 🗆 '	Yes 2 □ No	3 □ Pro	bably 4 DUnknown
The law recate has be page 2 sho	Completed								psy ormed?	prior to co death?	opsy findings available ompletion of cause of
10	0	25. Was case referred to medica	1				26. Place of Dea	1 Yes th (Check only o	2 No one)	1 ∐Yes	2 140
nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	ler: 4 ☐ Nursing H	ome 5 Resi	dence 6 □	Other (Speci	ify)
ding Pt J. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi	9	of Injury oth, Day Year)	28b. Time of Injury	Wor	ry at rk? Yes 2 □ No	28d. Describe	how injury occ	curred	
Attender! death	ficat	3 Suicide 6 Could	not be 28e. Place			eet, factory, office	100 2 100			mber or Rur	ral Route Number,
s after at Dire	Certification:	4 ☐ Homicide determ	bulld	ing, etc. (Specif	y) 			City or To	wn, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		ng Physician: To the Examiner: On the b and mar								
To the within To the comp	Me	29b. Signature and title of certifie	Γ .	100A		29c. Licens			29d. Date sig		
		Mars	in U.U	MILLY		D2374	3		Apr	il 2,	2008
10+1		30. Name and address of person Martin Weltz,					Grant	1+ MT	20710		
Sta		Martin Weltz, 31. Date filed (Month, Day, Year) APR 0 8	2002	Registrar's Signa	ture	Ses .	, oreembe	it, MD	20/10		
Registr	ar	APRUS	2000	MRJ JU	No.	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5 200 S Physician ABRIL Ralph Carman Burns /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 04/17/1931 76 Maryland Director 215-28-8130 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 305 Breslin Road 21085 U.S.A. Funeral 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 XYes 2 No 1949-If Yes, Give Year or Dates: 1953 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 🏚 No Specify. ≥ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Distillerv and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernard Burns Anna May Walter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trau Pages 1 and 2 Dorothy Bryant (Wife) 305 Breslin Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 04/08/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21 Stin ture of Fu ral Service Licensee 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Imme 12. Cause (Final disease or condition resulting in death)

a. The Cause (Final disease or condition resulting in death) 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 38 KRS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any sealing to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical use as t E FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by PNEWMONIA 1 Yes 2 No 3 Probably 4 Onknown Completed MYPERFENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 140 1∐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ppatient 은 After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 🗋 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier D0056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 500 Upper Chesapak Dr. Bel Lir, Mo 2101 Bicobaum 31. Date filed (Month, Day, Year) State APR 0 8 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year 3:16 PM 1001 BROWN GLIST 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE OF MARYLAND UNIVERSIT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Feb 6, 2008 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F 9. Birthplace (State or Foreign **Funeral** Months 214-81-1669 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits N/A MDBaltimore 1 X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2530 East Biddle Street 21213 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black <u>\$</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Durran Lamont Lilly Elise Michele Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elise Brown-Mother 2530 E. Biddle St., Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. 4.11.2008 Baltimore, MD Carmel Cem 4. □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Acensee 22. Name and Address of Facility

John L. Williams Funeral Directors, P.A. Much 1701 McCulloh St. Baltimore, MD 21217 23a. P.111. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NECROTISING ENTEROCOLITIS 36thrs TULMINANT /Medical Due to (or as a consequence of): **Examiner** EMATURIT if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed? Yes 2 No page certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No P 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Naturai 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

To the Hospital or Attending Physician:

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 0 8 2008

Redla

M. Akenolo ND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

inola, MD 32 Registrar's Signature

3. Greene Street,

29c. License number

16799

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 65 : 30AM Herman Levi Brooks APR 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Oct. 16, 19 **Funeral** Days Hours Min. Months 1 ★M 2 ☐ F 216-34-4561 70 1937 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6406 Woodgreen Circle 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No African-American þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer Harvest & Walker 12to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Brooks Sr. Sadie Pitts ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley L. Barnes Brooks/Wife <u>6406 Woodgreen Circle, Gwynn Oak, MD 21207</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Cemetery 4-10-08 Elkridge, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funer Service Licens 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 7 dw neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YPERTEN Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-trans and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte 4☐Pregnant at time of death 9☐Unknown Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Hospital Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely 29c. License number

State

Registrar

MOHAMMED

D AMIRA MOHAMMED SIYAM, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WHION MEMORIAL

APR.IL ZÓS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Baker Month **Physician** April 2008 3123 PM abonte /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** Baltimore Hospital The Johns Hookins n/a ear If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛛 F Min. Hours 219-21-7016 38 8-24-1969 Director DCUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 No notified Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 21157 USA by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: African-American 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Early Edication Development Teacher or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Kevin Scott Arvillia F. Baker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health at Important: If item 27 is any Injury or other trau Arvillia Baker-Pinkston/mother 311 North Colonial Ave. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Cramatory 4-9-08 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Willie Funeral Home P.A. of Balto. Co. 21. Signal (re of Funeral Septice Licenses 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or use on each line. Approximate nterval Between Onset and Death Immediate Cause (Final roke **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be bromatosis Neuro. 1 ☐ Yes Ż**Ų** No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA After this Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c, License number 29b. Signature 29d. Date signed (Month. Dav. Year) completed cause of death (Item 23a) (Type, Print)
e Johas Hoskins Hospital , Low N wolfe Street hiavi Hopkins

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20b perfh, 8878,04/08/08/08/08/08 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Day APRIL Erna РМ Baer 2008 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/22/1906 Birthplace (State or Foreign Country) **Funeral** Months Days 213-74-758 1 □ M 2 🛛 F Hours Director 101 GERMANY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Event than ust be notified at 1 ☐ Yes 2 No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE, #331 21208 USA Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 ∐Yes 2 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Ś If Yes, Give Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ADOLPH KRAEMER ROSALIA KAUFMANN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERIC BAER / SON 2 MORNINGTON LANE, CLEVELAND HEIGHTS, OH 44106 20a. Method of Disposition 20b. Place of Disposition (Name chesed 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 D Burial 2 □ Cremation 3 □ Removal from State CHEVRA AHAVAS CHESAD 04/06/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caured the death. Do not enter the mode of dying shock, or heart failure. List only one cause on early fline. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi gg/ P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown ts been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate | 1 ∐ Yes 2 🗆 No 1 TYes 2 100 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital; Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) and address of pers cause of death (Item 23a) (Type, Print) warry Labo D. BACTIMILE M& 21209 Osten 6dr-12 Heubert

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

APR 08

DOUB

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per ftp 878 4-8-08 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Darnell Cherry 04 01 2008 1:00a. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Months Hours 1 € M 2 □ F Yrs. Director 214-66-7105 52 80 19 55 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any fnjury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 XYes 2 No Directo MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3916 Bereva Road Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married / 1 / 0 8 | ; O Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Construction Co. Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie Lear Roscoe Elbert Cherry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Cherry-Sister 3916 Bereva Road, Baltimore, Md 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 4/5/08 Baltimore, Md Metro Crematory Inc 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West Gladie waner 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Yeavs /Medical Due to (or as a cons r uence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diverto for es e consequence of: Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\triangle \text{Nursing Home} \) 5 \(\triangle \text{Residence} \) 6 \(\text{Oher} \) (Specify) 1 Yes 2D No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ Naspice 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 h one) 29b. Signature and title of certifier 29c. License number Name and address opperson who completed cause of death (Item 23a) (Type, Print) Ave Baltimore MD 101 31. Date filed (Most Registrar's Signature State Registrar

State Registrar 3900 LOCH

2+1

BALTIMURE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 'egielski 9-50 AM n Ihonu March 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days **™** M 2□ F Yrs. 214-18-2843 87 June3,1920 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is an arked other than "hatural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 🎇 ☐ No Director Md. Howard Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2098 St. James Road 21104 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify. þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 t h College (1-4or 5+) Inspector General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Cegielski Anna Kocemski ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2098 St.James Road Marriottsville, Md21104 Frank Graczyk (grandson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State St. Stanislaus Cem 4-5-2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine and A The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA ပ this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30641

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) APR 08

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)
Ramen Sakapathi 201-109 Back River Neck Road baltimine Mayland

ampred se trype operinten 18878 indehole int Ensure All Copies Are Legible. 1. Decedent's Name (First Middle, Last)

Mildred B. Cooper

BRENDA 2. Date of Death 3. Time of Death aka Brenda M. Cooper COUPER APRIL **Physician** 2008 03 7:50 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A 9. Birthplace (State or Foreign Country)

OH 8. Date of Birth (Month, Day, Year 02/28/1916 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Months Days Hours Min. Director 295-03-2559 92 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits BERGEN 1 ☐Yes 2 No Director BERGER TEANECK NJ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 293 EDGEWOOD AVENUE 07666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MUSICIAN MUSIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BRENNER SOPHIE BOYARSKY MORRIS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NEWTON, MA 30 HAMLIN ROAD, 02459 THOMAS COOPER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State CEDAR PARK 1 ☐ Burial 2 ☐ Cremation 3 💆 Removal from State permit. Page Department o Important: If any Injury or 04/03/2008 EMERSON, NJ 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Juneral Service Lio 21. Signy 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications shock, or heart failure. List only one caus ons that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Zuede /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) nas been signed by the e 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 200 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed rector, page 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury Natural 5 Pending 2 Accident investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) 04/03/2008 12 and address of person who,completed cause of death (Item 23a)/(Type, Print) Evindule 2434 W Belvedere 21215 an

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 0 4 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ам 04/05/2008 01:45 Anthea C. DeMedis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Manor Care Towson Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day,) October 3, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 92 1 □ M 2 👿 F 217-05-5235 Greece Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Maryland Baltimore Towson 1 ☐ Yes 2 X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 509 E. Joppa Road 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Thomas Menas Marcella Zannicos ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. 7925 York Road Room 341 Towson Maryland 21204 Mary M. Moreland/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/8/08 Greek Cemetery Baltimore Maryland Leonard J. Ruck allow 5305 Harrord Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emen Due to (or as a consequence of): Examine Completed by Physician/Medical

Physician /Medical Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show idical Examiner must be notified at

27 is marked other than traumatic event, the Me

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Be Medical Certification: To within 24 hours after death

To the Funeral Director:

To the Hospital or Attending Physlcian: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, it was the formal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 3 □ Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknow
		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
1 ☐ Yes 2 ⊠aNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Ho	ne 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) n	28d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Pt	ysiclan: To the best of my knowledge, death occurred at the time, date and place, miner: On the basis of examination and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

29c. License number

H0054424

29d. Date signed (Month, Day, Year)

4-7-08

State Registrar 31. Date filed (Month, Day, Year) APR 0 8 2008

Asadi.

29b. Signature and title of certifier

Cyrus

20 E. Timonium rd. #209 Timonium, MD 21093 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20b per 1h 98/8 4-8-08 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 3 **Physician** Bernice Jackson Drayton Deborah March /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town or Location of Death Examiner 5. Social Security Nymber 7. Age (Intyrs. last birthday) Himore I Year If Uni 6. Sex nera If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours 1□M **%**□F Months Director 212-62-8432 15 52 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Catonsville MDBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 408 Shadetree Place Apt C Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mass Transit marked other than Elementary/Secondary (0-12) College (1-4or 5+) 2yrs the 12th grade Administration Authority permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James B. Jackson Bernice Clark 2 19a. Informant's Name/Relationship (Type. Print)
Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Shadetree Place, Catonsville, Md 21228 Tiffany Pitts Churchill 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8 Crematory Inc 4/7/08 Baltimore, Md ure of Funeral Service Licensee Signat 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Th. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advanced Acquired Immune Deficiency
Due to (or as a consequence br): disease or condition resulting in death) /Medical Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signature should it 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 s¹ 24a. Was an autopsy performe 1∐ Yes 1 Yes 2 No 2 **X** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this After thi funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Funeral Director: tely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 24 h To the Fur (Check only one) 29c. License number 29b. Signature and title of ertifie 29d. Date signed (Month, Day, Year) 29 00066568 -0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Owusu-Antwi mo. 40 Maryland 31. Date filed (Month, Day, . Registrar's Signature State Registrar

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Dorothy Mae Du		1- For State	Sta	ate of Maryland	•		ent of I a <i>te of L</i>		nd Men	ıtal Hy	_		200	18 1125
Physicia		Registrar 1. Decedent's Name	e (First, Middle	e,Last)		111100	110 07 2	- Catif		2	2. Date of Deat			3. Time of Death
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Funeral Director		5. Social Security N 212-22-			ge (In yrs. I 82			If Under 1 Yes		1 dies	1	•	D/YYYY) 9. Bi	irthplace (State or Foreign ountry) aryland
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Baltil permit. Departm Importa		21. Signature of Fur	6	Licensee			22. Na	ne and Addres	s of Facilit	Schi	munek	Fune	ral Hor	me of BelAir
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Boy e death the atte	Physi	1 Yes 2 🗸 N	lo 9 Unk	nown 9 Unknown		3	Otne	(Specify)						
Division of Vital Records, P.O. Box 68760, To the Hospital or attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—tra	ē	Part II. Other signif	icant conditi	ons contributing to dea	th but not r	esulting	in the und	lerlying cause	given in Pa	art I.	_			o the cause of death? obably 4 🗹 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after cleath. 11 Director: After this certificate has been silted in by the funeral director, page 2 should the funeral director, page 2 should the	oleted										24a. Was autop			autopsy findings available completion of cause of
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To the Hos within 24 h To the Fur completely	Medical			ysician: To the best of r niner:On the basis of ex- and manner stated	amination a									
F § F 8	Me	29b. Signature and	title of certifier						se number			29d. D	ate signed (M	lonth, Day, Year)
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		30. Name and address Pamela E. S	-	who completed cause of D Assistant Med		,	111	Penn Stree	et, Baltin	nore, M	D 21201	·		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 4-1-2008 2400 /Medical Paul J. Dembny 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson Gilchrist Balto. Co. 6 Sex If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₹M 2 □ F Months Hours Min 84 Director 216-14-0997 Usual Residence of Decedent 6-21-1923 Maryland 10c. City, Town or Location 10d, Inside City Limits 1∩a State 10h County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Modical Exercises must be notified a Parkville Md. Director 1 ☐ Yes 2X ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 8810 Walther Blvd. Apt. 1412 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: q White 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Manager 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helena M. Kapralek ይ Joseph F. Dembny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once. 1208 Runnymede Lane BelAir, Md. 21014 Marci LaRue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 4-5-2008 Balto.Md. 21. Signature of Suneral Service ensee 22 Name and Address of Facility e. Schimunek Funeral Home 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner WEEKS PNEUMINIA Sequentially list conditions Examiner Due to (or as a consequence of) it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No 4 Pregnant at time of death Month Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> EMPHUSE-MA DIA BETES 1 Yes 2 No 3 Probably 4 Unknown is certificate has been s director, page 2 should i Completed DEMENTIA CORONARY ARTERY DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy performed? CARDIOMYOPATHY 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence State (Specify) HDS P/CL-1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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this

After t

funeral

and

28a-f show

2 should be filed within 72 hours after death with in and Mental Hygiene.
Is marked other than "natural", or items 23a or ?

Saltimore, Maryland 21215-0036

the

Registrar

Medical

DANIEUE 31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

<u> APR 0-8</u>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OCBERMAN, MO

and manner stated.

32. Registrar's Signature

6565 N CHARLES ST. SHITE 209 BALTIMIRE MD 21204

29c. License number

D 64395

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RONALD JOHN DOHLER APRIL 2008 7:45p ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or I ocation of Death Examiner 1332 SPRING AVENUE BALTIMORE ROSEDALE 8. Date of Birth (Month, Day, Year) 1 / 21 / 1939 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min. 1 M 2 F MARYLAND 69 213-34-8397 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE ROSEDALE 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 1332 SPRING AVENUE 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: ≥ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Is marked other than MILLWRIGHT FIELD SUPERVISOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental H ARTHUR DOHLER JOSEPHINE 2 MUSTAL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If Item 27 Is any injury or other trau BRENDA P. DOHLER/SPOUSE 1332 SPRING AVE BALTIMORE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 4/8/08 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic -22. Name and Address of Facility CVACH / ROSEDALE 1211 CHESACO AVE BALTIMORE, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician WEEKS disease or condition resulting in death) ACUTE PANCREATITIS /Medical Due to (or as a consequence of): Examiner 11 GALL STONE/GBD Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed DIFFIULE COLITIS e EMAUTION e DEHYDRATION burial-trar and Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1□Yes 2□No for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy perform 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? I or Attending Patter death. 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: A 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide the Hospital of the Hours at 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2. 29b. Signat 29c. License number D0020170 0 (Item 23a) (Type, Print) 30. Name and DRIVE SUITE 509 TOWSON DR. 7505 LTOSE Α W. D OSLER MD 21204 HERNANDEZ. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

APR 08

2008

Amend Item 23a per dr., g891,05/05/09dhb State of Maryland / Department of Health and Mental Hygiene Hegistrar Amend Item 16b per fh, g878,04/08/08dhb Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APRIL Mollie 2008 5:00 Ам Eisenberg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JEWISH CONVALESCENT & NURSING BALTIMORE BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 06/26/1908 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Min 212-44-8973 99 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f shorner must be notified at MD N/A BALTIMORE Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 3031 FALLSTAFF ROAD, APT. 505 USA 21209 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours afte. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or in any injury or other traumatic event, the Medical Experimona. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Eisenberg's Deli RISENBERG'S DEL Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) SILBERSTEIN SOLOMON JACOBSON IDA ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL EISENBERG / SON 3031 FALLSTAFF RD., APT. 505, BALTIMORE,MD 21209 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 D Burial 2 □ Cremation 3 □ Removal from State ANSHE NEISEN 04/06/2008 | ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 JUC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Acute Myocard al Infarction** Immediate Cause (Final **Physician** 2nemo disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) □Yes 2□No P.O. been signed by the s should be detached 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? Division of Vital Records, δ 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 □Yes 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖳 N Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 27. Manner of D 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 12 (con 000 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 APR 08 Registrar

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	i.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
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	Funeral Director	ji.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 1 Mn. Usual Residence of Decedent
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	h the Mar 3a or 28s	Director	10e. Street and Number 1600 Pulaskii St. 10f. Zip Code 2/2/7 10g. Citizen of What Country?
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	xaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):
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	Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The funeral Director: After this certificate has been signed by the attending physician and opletely filled in by the funeral director, age 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
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29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. April 3, 2008 30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Zabiullah Ali, M.D. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

APR 0 8

32 Registrar's Signature

OCME

11258

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, I'm Mulcal Examinar must be notified at any injury or other traumatic event, I'm Mulcal Examinar must be notified at ange. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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S E	Funeral	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.	S. 13.\	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		Race - Ame	erican Indian,	
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is ce direc	.0	examiner? 1 ☐ Yes 2 🗖	No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Ho	ome 5 Resid	ence 6 X	Other (Sp	ASSISTED	
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din	ert	4 Homicide		building, e	тс. (Бресп	<i>y)</i>			City or Tow	n, State)			
nera / fille		29a. Certifier	X Certifyin	g Physician: To the bes	of my kno	wledge, deat	h occurred at the tir	me, date and place	, and due to the	cause(s) and	manner a	as stated.	
e Fu	Medical	(Check only one)	2 Medical 8	Examiner: On the basis and manner s	of examina	ation and/or in	vestigation, in my o	ppinion, death occur	rred at the time, o	date and pla	ce, and du	e to the cause(s)	
To the Funeral Director: After this certificate has been signed by the att completely filled in by the funeral director, page 2 should be detached for	Me	29b. Signature and	title of certifier				29c. Licens	e number	2	9d. Date sig	gned (Mon	th, Day, Year)	
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		30. Name and add	ess of person	tho completed cause of	death (Iton	n 23a) (Tvne	Print)	7 17 (1100		
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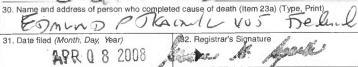
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April **Physician** 2008 10:00 AM Margaret E. Firor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner None St. Elizabeth's Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 2, . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1922 Days Hours 1 □ M 2 □ F Virginia 85 214 14 1540 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 United States 9233 W. Stayman Drive "natural", or items 23a within 72 hours after death Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 ò Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie Cantwell Hugh K. Arnold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra Klinedinst/Daughter 9383 Furrow Avenue Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-9-2008 Ellicott City, MD St. Johns Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Box 68760. physician pe Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day for in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.0. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an te has a autopsy perform 1∐ Yes 2⊠No certifica or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending investigation 1 Yes 2 No ours after death. 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

31. Date filed (Month, Day, Year) State APR 0 8 2008 Registrar

29b. Signature and tifle of certifier

EDMUND



29d. Date signed (Month, Day, Year)

Al dute 100 CAMO 1/200 11207

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 35 PM M Howard Wellington George, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Restale 1 Year | If Under 24 Hrs. Bailtimore Square. 5. Social Security Number 6. Sex 1 1 M 2 □ F If Under 8. Date of Birth Month, Day, Year) Dec. 18, 1933 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 74 Months Min 219-28-1892 Baltimore, MD. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 →Yes 2 No Baltimore N/A Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1030 Lerew Way 21205 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Gas Station Attendant Gas Station n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kenneth Aquilla George Edna Anna Virginia Chalk 19a. Informant's Name/Relationship (Type. Print) (SO11) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Howard Wellington George, Jr. 1030 Lerew Way Baltimore, Maryland 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) April 2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service License Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) ue to (or as a consequence spiration if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed. Yes 2 No TYPE 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Physician /Medical **Examiner** Examiner be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

"natural", or Items 23a or 28a-f shov edical Examiner must be notified at

or other traumatic event, the Medical

permit, Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumation.

Funeral

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Completed

Be

sician and burial-transit attending physician Physician/Medical the as nse ate has been signed by the atter page 2 should be detached for i 2 Completed Be P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Division or Vital Records, P.O. Box 68760,

9 Unknown

Diahetes meilitus

25. Was case referred to medical examiner?

determined

1 Tyes

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

4 Homicide

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Jin Square Drive

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Certification:

Medical

State Registrar

2. Registrar's Signature 31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** Month N. Galloway Jr. Randolph 2008 04 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Seasons Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Year) **№** M 2 🗆 F 249-90-5280 51 07 14 **Director** 56 NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore 1 X Yes 2 □ No MD NA Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21215 U.S.A. 3708 Oakmont Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify Black ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Televison Company Mailroom Clerk 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Hatfield Randolph Galloway Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Paltimore, Md 21215 19a. Informant's Name/Relationship (Type. Print) 3708 Oakmont Ave, Baltimore, Md Nancy Galloway-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc 4/10/08 4 □ Donation 5 □ Other (Specify) Baltimore, Md 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician pancreolie concer resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit that initiated events resulting in death) Last that the death certificate be execu-Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Q Other (Specify) Topot Hospice 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 X Natural 1 ∏Yes 2 ∏No 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending within 24 hours after death. To the Funeral

> State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifie

cal

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Briela YO'8

1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 1.15 AM 04 රු DAVID GARCIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Univ of Maryland Medical Center n/a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 ☐ F 1947 California 572-60-6133 Jan 12, 61 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No Directo Maryland Anne Arundel Odenton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 848 Harvest Moon Drive 21113 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates:1966-90 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyres 2 □ No Specify: Mexican Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. State Department Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Garcia Guadalupe Gonzales Aguilar David 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Odenton, Maryland 21113 Linda Wells Garcia/wife <u>848 Harvest Moon Drive</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Ceme 4/30/2008 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 21. Sign to e of Funeral Service Li Himos 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Henorhe one day **Physician** Intracerebal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 20 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2. No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No **Division or Vital** Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ecritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of rson who completed cause of death (Item 23a) (Type, Print)

22 S GREENE ST

32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

P 25506

BALTIMORE MO ZIZOI

29d. Date signed (Month, Day, Year)

/3/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 01:45 AM ROSALIE GARRETT 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Town, or Location of Death Baltimore rustdale Hospital 8. Date of Birth (Month, Day, Ye JULY 4, If Under 1 Year | If Under 24 Hrs. Social Security Number L 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours , 1918 MARYLAND Days Months 1 □ M 🔏 F 89 216 14 3394 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MD BALTIMORE 1 ☐ Yes 2 X No Director ROSEDALE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 103 ASPINWOOD WAY APT E 21237 Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items; any Injury or other traumatic event. the Marian Exer 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ZIMMERMAN EMMA ပ WILLIAM KELLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joann GLOWACKI / DAUGHTER 6411 GOLDEN RING RD BALTIMORE, MD 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State METRO CREMATORY 4/10/08 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transil Due to (or as a consequence of): Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 1 No page 2 certificate 1 Yes Division or Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No ၉ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manyer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 ☐ Pending investigation To the Hospital or Attending Injury 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Cina, mo

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

9000 Franklin Square

2. Registrar's Signature

29c. License number

Drive, Baltimone, Maryland

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** Wayne Clark Gardner 2008 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** odicist Center 01 HOSDITAL DR 7. Age (In yrs. last birthday) BULDIE BALTIMORE WAShirston Modicial ANNE ARUNDE Lew 5. Social Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Days Hours 57 214-56-2256 Aug.1,1950 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits If Item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Directo Anne Arundel Severna Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 279 Riverdale Road 21146 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 Married 1□Yes 2█ No White Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Health and Mental Hygiene. College (1-4or 5+) Sub Contractor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Albert Gardner Rose A. Smith ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Mary Gardner /Wife 279 Riverdale Road Severna Park MD 21146 permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State April 12, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M01479 Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 00 resulting in death) /Medical ue to (or as a consequence of): Examiner NOW Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 ed by the attending physician detached for use as the buria Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2∐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2☐ No 2 ER/Outpatient 3□ DOA 1 🔲 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of D 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Ham al Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 pegistrar's Signature Year) 32. 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Dav Year **Physician** GEO? GE J. GRAH AM 11:43 AM ADRIC 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Jown, or Location of Death Examiner tumor N If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 №M 2 ☐ F 219-26-Carolina Director outh Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10d. Inside Çity Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director Ma. thmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r nothing 2,229 Funeral ham 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ACE 10+4 s 1 and 2 should be filed v if Health and Mental Hygie item 27 is marked other t other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kosa Coopers ပ 19a_Informant's Name/Pelationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Graham-daughte Ave 6 Balto. Winston permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr md1 21212 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -ING mem. -10-08 Kandaelstown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Los see 22. Name and Address of Facility XMI Jan 23a. Part . Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SHOCK SEPTIC HOURS /Medical Due to (or as a consequence of): **Examiner** ABUSE CHRONIC ALCO HUL Sequentially list conditions, if any leading L. Innividual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner that the death certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 NOTEIN MALNUTRITION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a Was an autopsy performed? Yes 2 No page 2 1∐ Yes Vital Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 1 ☐ Yes 2 No 3□ DOA Certification: To 2 ER/Outpatient 0 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Property Appendix Property Appendix Property Appendix Property Appendix Property Propert 2 Accident 6 □ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier To the Fune completely f (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO APRIL 05, 2008 D66335 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar GORNEY

31. Date filed (Month, Day, Year)

APR 0 8 2008

32 Registrar's Signature

NIVERSITZ

22 SOUTH GREENE

of MD

08-02622	
Lloyd Gallatin	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oyd Gallatin		Redistrar	ent of Health and Mental Hy ate of Death	giene Reg.	No. 2008	268
Physici ledical Exami	an/	Decedent's Name (First, Middle,Last) LLOYD CORNELIUS GALLATIN		2. Date of Death Month D	3. Time of Death	th
A	nei	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	April 3, 2008	4c. County of Death	
		3200 Auchentoroly Terrace	Baltimore		N/A	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 219-50-1009 1X M 2 F 58	hday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth()	MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) MARYL	
пу		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City	
Aaryland 28a-f show any 1 at once.	_				1 X Yes 2	No
arylan 8a-fsl atono	Director	10e. Street and Number	IMORE 10f, Zip Code	10g.	. Citizen of What Country?	
with the Maryland ns 23a or 28a-f sho be notified at once.		3200 AUCHENTOROLY TERRACE	21217		USA	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tenth and Mental Hygeria. ten 27 is marked other than "natural", or items 23a or 28a-f 5the traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black White, etc.	:k,
after c al", or	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: BLACK	
hours natur Exami		15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retire		6b. Kind of Business/Industry	
36 hin 72 e. than "	ompleted	Elementary/Secondary (0-12)	NVIRONMENTAL SPEACIA	LIST	FEDERAL GOVERNME	ידואי
d with	Com	17. Father's Name (First, Middle, Last)	18.Mother's Name			1111
21215-0036 uld be filed within 72 hours : Mental Hygiene. marked other than "naturz revent, the Medical Exami	Be	LLOYD GALLATIN SR.	JOANN	WILLIAMS		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygener. Important: If item 27 is marked other thinjury or other traumatic event, the Med	7	11111	b. Mailing Address (Street and Number or R			
MD and 2 sho alth and em 27 is			519 LINDEN AVE. APT of Disposition (Name of cemetery,		ORE, MARYLAND 212 20c. Location - City or Town, State	.1/
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Buria 2 Cremation 3 Removal from State cremat	ory or other place)		•	
tim t. Pag tment rtant:	- 3	, total series of the series o	ON FOREST VETERANS 4	-10-200B	OWINGS MILLS, MA	RYLA
Bal permi Depar Impo injur	lj. lj	21. Signature of Fine gay Service License JONATHAN D. HIB	1721-27 N. MONROE			
Physician		23a P 1 I. Enter the disease, or complications that caused the death. Do no			t, shock, or heart Approximate	Interval
/Medical	ni i	fa'ure. List only one cause on each line. Immediate Cause (Final disease a, Hypertensive Atherosclerotic	c Cardiovascular Disease		Between Ons Death	
-xaminer		or condition resulting in death) Due to (or as a consequence of):				
	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	miner	cause. Enter Underlying Cause (Disease or injury that initiated				
ded /	Exal	events resulting in death) Last Due to (or as a consequence of):				
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60, ate be o hysicia e buria	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		··	23d. Date of delivery	
Records, P.O. Box 68760, The law requires that the death certificate by case has been signed by the attending physic page 2 should be detacted for use as the bur	sician/M	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna	ncy		'ear
OX (eath ce sattence for use	sici	4 Pregnant at time of death 1 Yes 2 No 9 Unknown	Other (Specify)			
D. B t the d by the	Phy		g in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of dea	ath?
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rds, P.O.	Completed			24a. Was an autopsy		
eco he law ite has	ᄩ			perform 1 ✓ Yes 2	ed? death?	No
	ادها	25. Was case referred to medical	26.Place of Death (Check	only one)		
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_ = ~ 2	١	(Month, Day, Year)	Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
Sior vittend death ctor: y the	ă	2 Accident Investigation	1 Yes 2 No	001 1 - 11 (0)		. 00
Division tal or Attendir rs after death. al Director: A	ertification:	Suicide Could not be determined (Specific)	arm, street, factory, office building, etc.	or Town, Sta	reet and Number or Rural Route Numb ite)	ser, City
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifiety filled in by the funeral director,	0	29a. Certifier	ath occurred at the time, date and place, and	due to the cause(s) and manner as stated	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical	one) 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurred a	at the time, date ar	nd place, and due to the cause(s)	
To To Cor	ĕ	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)	<u> </u>
		(Landuckey 10	O.C.M.E.		April 3, 2008	
/x\		30. Name and address of person who completed cause of death (Item 23a)				
5x1			1 Penn Street, Baltimore, MD 212	01		
S Regis	tate	71711 11 U 17011 U 1874 KA	locally !			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Monetta R. Gross April 2008 4:08 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare Spa Creek Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F Director 214 14 9996 Feb 11, 1923 Pennsylvania Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural, or Itema 23e or 28a-f shov the Medical Examinar must be retified at Director 1 ☐ Yes 2 XNo MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4050 Crescent Rd 21042 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after dial Hygiene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ģ 3 € Widowed 4 Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Restaurant traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked out Russell Dobson Sarah Berkebile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie McQuaid/Daughter 9424 Tiller Drive Ellicott City, MD 21042 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department Important: If any injury or once. Ardent Crematory 4-10-2008 Hanover, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 all Thy 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** women 10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit be executed Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 NO 2 No or Attending Physician; funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: Anursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 252No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

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completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

30. Name and address of person

32. Registrar's Signature

We

who completed cause of death (Item 23a) (Type, Print)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2008 9:55 Gladys F. Hagen April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Manor Care Woodbridge Valley Catonsville If Under 1 Year | if Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April 20,1910 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months 97 217-07-1501 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or; any injury or other traumatic event, the Medical Examiner must be nonce. 21228 2212 Pleasant Drive **USA** Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2 🛣 No Specify Specify: White Completed by 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Clifton Deal Sr. Anna Fousek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Helm, Daughter 2212 Pleasant Drive Catonsville, Maryland 21228 20b. Place of Disposition (Name of cametery crematory or other place)
More Land
Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/11/08 Parkville, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor 2 Mac Nabo Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2) No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manual of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attent within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o 29b. Signature and tile of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-16W. Roll marce

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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08-02653 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kathy Jane Holland State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ 1149 hrs Medical Examiner April 4, 2008 Kathy Jane Holland 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Nottingham **Baltimore County** 5 Ferns Way 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) Maryland Months Days Hours Min Director 12/22/1964 215-96-5640 43 1 M 2 XF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD. 1 Yes 2 X No Baltimore Nottingham the Maryland Director 10f, Zip Code 10e. Street and Numbe 10g, Citizen of What Country 5 Ferns Way 21236 USA **23a** Funeral 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married Yes 2 X No White Widowed 4 X Divorced If Yes, Give Yee Yes 2 X No specify: Specify: "natural" 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Restaurant Baltimore, MD 21215-0036 Waitress permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donald Joe Andrews Be Patricia Ann Alvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2933 Edgewood Ave. Baltimore, MD. Daughter Melissa Wildes/ 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 04/08/08 Parkville, MD. Parkwood Cemetery Donation 5 Other Specify: ²² Name and Address of Facility Evans Funeral Chapel & Cremation 8800 Harford Rd. Parkville, MD, 2 . Signature of Funeral Service Licenses 2 a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Cardiac Arrhythmia associated with Cocaine Us. mmediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) If any, leading to immediate Examine cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED 23a, 27 per ME g878 4/16/08 amh X UNPENDED ysician burial The law requires that the death certificate be Box 68760. ending phys use as the bu 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live hirth Fetal death Month Day past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has b performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 26 Place of Death (Check only one) 25. Was case referred to medical æ Other: examiner? Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification 1 X Natural 1 Yes 2 No Pending death. To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registral

OCME 2006

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State

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 5, 2008

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

)o oth	O Time of Dooth
Reg. No 2 0 0 8	1127

			1 - State Registrar	ertificate of Death	Reg. No.2008 1 270
	Physicia	an.	Decedent's Name (First, Middle, Last)	2. Date	e of Death 3. Time of Death
	/Medic	al	Joyce Ann Hillyard	HP	ril 3,2008 8,19 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Formal		Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Hagerstown avi If Under 1 Year If Under 24 Hrs. 8. Date	washington e of Birth 9. Birthplace (State or Foreign
	Funeral Director		220-52-165 1 M 2 F 6 Yrs Usual Residence of Decedent	Months Days Hours Min. (Mon	19,1946 Pennsylvania
	yland now at		10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	e Mar a-fsl	ctor	Maryland Washington	Hagerstown	1 No 2 No
	ith th or 28 be no	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	sral	107 S. Mulberry Street	21740	S or No- 14. Race - American Indian,
	ter de item	E C	11. Marital Status 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Yes 2 ▼ No.	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 	etc.) Black, White, etc.
920	urs af al", or Exam	ě	' 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	Specify: White
5-0036	iled within 72 hours after death with the Maryland Hygiene. viher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of working	16b. Kind of Business/Industry
2121	2 should be filed within and Mental Hygiene. is marked other than "raumatic event, the Mer	npf m	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working e. DO NOT use retired)	11 111 6.70
	iled w Hygie ther t nt, th	ပ္ပ	17. Father's Name (First, Middle, Last)	Jursing Aide 18. Mother's Name (First,	Health Care
Maryland	d be i	To Be			vice Fox
J.	shoul nd M marl	ř		ailing Address (Street and Number or Rural Route	
	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Patsy Payton / Friend 10	15. Mulberry Street	Hagerstown, MD 21740
ore	of He fitem		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	sposition (Name of Date crematory or other place)	20c. Location - City or Town, State
Ë	Pages ment of l		4. □ Other (Specify) Anatom	46. As Registry April 4,200	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of uneral Service Licensee	22. Name and Address of Facility Anaton	ny Gifts Registry e suite P. Harrier, MD 21076
	40 = 10 0		23a. Part1. Enter the disease, or complications that caused the death. Do not		
	Discoulation in		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	linea	6 min Mo
	Examiner				
1	T #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
P	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events c		
60,	icate be executed physician and s the burial-transit				
68760	icate physi s the I	Medical	d		
Box (The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit				23d. Date of delivery
-	death ce e attendir ed for use	icia	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
P.0	res that the de signed by the be detached t	Physician/	9□Unknown 9□Unknown		
	res tha igned be de	by		e underlying cause given in Part I. 23e	e. Did tobacco use contribute to the cause of death?
oro	w requir been si should I	Completed			1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
3ec	has b	adr.		248	a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
or Vital Records,					Yes 2 No 1 Yes 2 No
>	Physician: rthis certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	26. Place of Death (Check	
0	<u>a</u> + <u>a</u>	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at 28d. De	☐ Residence 6 ☐ Other (Specify) scribe how injury occurred
ion	ath. rr: Aft	atio	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation	M 1 Yes 2 No	
Division	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Loc City	ation (Street and Number or Rural Route Number, r or Town, State)
	oital ours aff				
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1	eath occurred at the time, date and place, and due or investigation, in my opinion, death occurred at th	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
	o the	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	F>F0		Muchant I Ohn to A MC	041667	4.4.08
	\	-	30. Name and address of person who completed cause of death (Item 23a) (Tyl	pe, Print)	
	1		Michael McCorneck 11110	Medical Canyous	Merritum MD
rQ.	Sta Registr	- 1	31. Date filed (Month, Day, Year) 32. Registrar's Signature	medical Canyon	
DH	HMH 17 Rev 1/20		APR 0 8 2008 John 15. 19		

08-02645 Jessica Harvey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 1127

•		1- For State Registrar Certificate of Delication Certificate of Certificate		a montan m		g. No.	10 1121
Physicia	an/	Decedent's Name (First, Middle,Last)			Date of Death Month		3. Time of Death
ledical Exami	ner	Jessica Caryn Harvey	_		April 4, 200	08	0026 hrs
Ed 132			City, Town, or Baltimore	Location of Death		4c. County of Dea	ith
				. If I and a OAI Inc	O Date of Die	N/A	tirthology (State or
Funeral Director			f Under 1 Yea Months Day		-		eign Country)Maryland
Director		220-96-2923 1 M 2XF 28 Yrs.			bulle 1	0,13,3	country) - Garage - Garage
ri k	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
0 W 31		MD Baltimore Dundalk					1 Yes 2 No
rylanc a-f sh	흱	FID DGI OZINO	Of. Zip Code		10	g. Citizen of What Co	
e Ma or 28	Director		21222)		U.S.A.	
sath with the Maryland items 23a or 28a-f show any sst be notified at once.		6769 Woodley Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De		spanic Origin? (Sp	ecify Yes or No-		erican Indian, Black,
eath v	Funeral			n, Mexican, Puerto		White, etc.	
ifter d		3 Widowed 4 Divorced If Yes, Give Year or Dates:	es 2 X No	specify:		Specify: Whi	te
2 hours af "natural [Examin	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's L		tion (Give kind of v		16b. Kind of Busines	s/Industry
6 172 h an "n cal E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)		. DO NOT use rea	ieu)	0.11	
003 withir iene. er the	Completed	3 Stude				College	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)		18.Mother's Name		inn	
112 Id be Menta narke	To Be	Ronald Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	dress (Stree	4		ber, City or Town, Sta	ate Zin Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than or other traumatic event, the Medical	-		rcadia	Avenue	Chester,	Virginia	23831
and and lealth lealth		20a. Method of Disposition 20b. Place of Disposition	n (Name of ce		Date	20c. Location - City	
Baltimore, permit. Pages 1 at Department of He Important: If ite		Burial 2 X Cremation 3 Removal from State crematory or other Hilltop Serv	. ,	orp. 4	/9/08	Towson,	Maryland
Iltin nit. P artme ortan		4 Bonaton o Caro opeon).	e and Address	a of Facility			
Dep Dep In in ju	1	1 C Q a 8 1. C a	2 Wisa			Maryland	Oundalk, Inc.
Physician		23a. Part I. Eliter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.	node of dying,	such as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical -xaminer		Immediate Cause (Final disease a. Multiple Injuries					Death
Adminier		or condition resulting in death) Due to (or as a consequence of):				-	
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sit g V/	Xa	events resulting in death) Last Due to (or as a consequence of):					
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60, ate be e ohysicia e buria	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of deliv	•
876 tificat ng ph as the		23b. Was decedent pregnant in the	death 3	Ectopic pregna	ancy	Month	Day Year
Box 687 e death certific the attending p	icia	Pregnant at time of death 5 Other	(Specify)				
Bo ne dea the a	Physician	1 Yes 2 No 9 V Unknown 9 Unknown			Loo Bill		(death 0)
tal Records, P.O. Box 68' cina: The law requires that the death certifi certificate has been signed by the attending ector, page 2 should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the under	eriying cause	given in Paπ I.			to the cause of death?
S, F quires en sign ald be	Completed by				24a. Was		autopsy findings available
Ord aw red as be 2 shou	ble				autop		o completion of cause of
Rec The L	팃				1 Yes		
tal certifi	Be (25. Was case referred to medical examiner?	26.Place	of Death (Check			
of Vital Rec ling Physician: The After this certificate funeral director, page	P	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3					her:
ding Afte	ä	27. Manner of Death 1 Natural 5 Pending Apr 3, 2008 28a. Date of Injury Apr 3, 2008 2242 hrs		ıry at Work? Yes 2 ✔ No		now injury occurred auto auto collisio	n
Sio Atten r deat ector	cati	2 Accident Investigation 28e Place of Injury - At home farm street for			28f Location (S	Street and Number or	Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Certification:	Suicide Could not be determined (Specific) Land Change	actory, cinco i	bollaling, oto.	or Town, S		
lospit 4 hour uner		4 Homicide (Specify) Local Street 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	l at the time. d	ate and place, and			
the the mplet	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation,					
F 2 8 8	ş	and manner stated. 29b. Signature and title of certifier	29c. Licens	se number		29d. Date signed (#	Month, Day, Year)
		him ins	O.C.	M.E.		April 4, 2008	
		30. Name and address of person who completed cause of death (Item 23a)					
10		Ling Li, MD Assistant Medical Examiner 111 Penn Street, I	Baltimore,	MD 21201			I
		31. Date filed (Month, Day, Year) 32. Refistrar's Signature	# B				
Regis	Tel.	1DD 0 8 2008 Filmens of 1000	Contract of the Contract of th				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** IRVIN HENRY HABICHT 3:15 AM APRIL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death N/A SINA HOSPITAL OF BATTMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Yea 5/1/1924 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 ☐ F 216-20-9770 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Tyes 2X No Director MD BALTIMORE TIMONIUM 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code #101 1 MULLINGAR COURT 21093 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TYYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: þ WHITE 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED YEARS ATTORNEY I and 2 should be filed w lealth and Mental Hygier m 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAUL R. HABICHT WILHELMINA MARTIN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Important: If Item 27 is n #101 EUNICE HABICHT/WIFE 1 MULLINGAR COURT TIMONIUM, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST VET. 4/11/2008 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 □Removal from State CEMETERY 4/11/2000 CEMETERY 22 Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Li leatu 8521 LOCH RAVEN BLVD. TOWSON, MD 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FIBROSIS **Physician** PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncorpy of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran and Due to (or as a consequence of): Box 68760, attending physician be Physician/Medical the as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes ②■No 24a. Was an has page 2 autopsy perform certificate 1[2500 25. Was case referred to medical director Be 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Mopatient 2 After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ö 29a, Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061959 PRIL. 05, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 MD 21213 BALTIMORE AMAN SIBOL WEST BELVEDERE MVE MD 31. Date filed (Month Day, Year) Registrar's Signature State 2008 Registra

DHMH 17 Rev 1/2001

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Patricia	Houck

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State of Manyland / Department of Health and Mental Hygiene

atricia Houck		Sil-For State Registrar	tate of Maryland		it of Health and IV e of Death	lental Hygiene	2 0 (Reg. No.	08 1127
Physicia	ın/	1. Decedent's Name (First, Midd		1		2. Date of D Month March 3	eath	3. Time of Death 1618 hrs
Medical Examii		Patricia Henne 4a. Facility Name (if not institution			4b. City, Town, or Loca		1, 2008 4c. County of Dea	
I		Baltimore Washington	-		Glen Burnie		Anne Arunde	
Funeral Director		5. Social Security Number 212-60-2467	6. Sex 7. Age	e (In yrs. last birthda 56	**	Hours Min	20 , 1952	
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			10d. Inside City Limits
Maryland 28a-f show d at once.	ō		Arundel	Pasaden				1 Yes 2 No
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tems 2.	Funeral	11. Marital Status 1 Never Married 2 X N	12. Was Decedent Arried Armed Forces?		Was Decedent of Hispani If Yes, specify Cuban, Me		No- 14. Race - Am White, etc.	erican Indian, Black,
fter dez I", or i			1 Yes 2	X No	1 Yes 2 X No sp	pecify:	Specify: Wh	ite
hours a	ed by	15. Decedent's Education (Spo			cedent's Usual Occupation (ing most of working life. DO		16b. Kind of Busines	s/Industry
5-0036 ed within 72 hours a tygiene. other than "natura	Completed	Elementary/Secondary (0-12)) College (1-4 or 9		ensing Agent		Motor Veh Adminastr	nicle Pation
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the M dies		17. Father's Name (First, Middle				Nother's Name (First, Middl	e, Maiden Surname)	
2121 uld be f Mental marked: event,		George Henneman		19b. N	Ve Mailing Address (Street an	eronica Gregor d Number or Rural Route N	Or Number, City or Town, Sta	ate, Zip Code)
e, MD 2 1 and 2 shou Health and N item 27 is n		Dennis Houck/H			72 Twickenham			
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 1 X Burial 2 Crematic	on 3 Removal from St	ate Meadowi	Disposition (Name of cemeter of ether place)	Date 1 4-5-08	20c. Location - City	or Town, State , Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S	Specify: //	Pa	rk 22. Name and Address of F			
Ba perm Depri Imp		Danielle	L. Daughe		1328 Sulphur	Spring Rd.	Arbutus MD :	21227
Physician 'Medical		23a. Part I. Enter the disease/c failure. List only one cause	e on each line.	,		h as cardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and Death
, xaminer		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a cons		e Intoxication			
	Į.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):	·····			
==- u	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	e c					
cuted nd transit	Exa	events resulting in death) Last	dd.					
60, rate be executed physician and re burial - transit	Medical	X UNPENDED	<u> </u>		er ME g878 4/10/0	08 amh		
cath certificate be estatending physician for use as the burial	M/ug	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, outcome the Live birth	me of pregnancy 2	Fetal death 3 E	Ectopic pregnancy	23d. Date of deliving Month	very Day Year
Box 687, death certification attending ped for use as the	Physician/I		4 Pregnant at	time of death 5	Other (Specify)			
P.O. E that the d	y Ph	Part II. Other significant cond		h but not resulting it	n the underlying cause given		id tobacco use contribute	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staff cleath. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed by					1 24a. W	Yes 2 ✓ No 3 F	Probably 4 Unknown autopsy findings available
cords law requir has been a	Completed					au	utopsy prior terformed? prior terformed?	to completion of cause of
tal Rec		25. Was case referred to medic	al		26.Place of	Death (Check only one)	es 2 No 1 🗸	Yes 2 No
Vita hysicia this cer	To Be	examiner? 1 ✓ Yes 2 No		ent 2 🗸 ER/Outp	patient 3 DOA Oth	er4 Nursing Home 5	Residence 6 Ot	her:
Division of pital or Attending Phours after death. Peral Director: After Iffiled in by the funeral		27. Manner of Death 1 Natural 5 Per	28a. Date of Inju (Month, Day,)		ne of Injury 28c. Injury a	2 V No.	be how injury occurred	
isio	ficati	2 Accident Inv	estigation 3/31/08	Fnd 3 njury - At home, farm	n, street, factory, office build	Subjection etc. 28f Location	t ingested med	Rural Route Number City
Div pital o ours aft	Certification:	4 Homicide det	ermined (Specify) Sin	gle family			n, State)1672 Twick na, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transi	Medical		Physician: To the best of maminer: On the basis of exa and manner stated.					
£ ½ ½ 8	Me	29b. Signature and title of certif	fier / A		29 c. License nu		29d. Date signed (Month, Day, Year)
		Joshe	Jeen		O.C.M.E	<u> </u>	April 1, 2008	
		30. Name and address of person Tasha Greenberg MI			111 Penn Street, Ba	ltimore, MD 21201		
	ate	31. Date filed (Month, Day, Year APR 0.8	0000	ar's Signature	P			
Regist	Helf.	HER U O	2008	2 67 64	No. 18 P			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Mildred M. Heinle 4-4-2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1603 Thornwood Ct. Fallston 5 4 1 Harford Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 F Director 88 5-27-1919 Md 215-01-2856 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director Md. Harford Fallston 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1603 Thornwood Ct. 21047 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If Item 27 Is marked other any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Conrad Breitschwerdt Marie Laubach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fallston, Md Date 20c. Location - City or Town, State Lawrence Heinle, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Parkwood 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Lie. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ABUTES **Physician** 000 /Medical Due to (or as a consequence of) ATTACT DEMENTIA **Examiner** So uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 mop Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other sign icant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SO ARA 513 P No 3 Probably 4 Unknown Completed 15/2/11/ 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1☐ Yes 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 8025 414/2008 Chaparo Ave, Balh, MD21237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RNI,

DHMH 17 Rev 1/2001

State

Registrar

SOHAIL 31. Date filed (Month, Day, Year)

APR 08

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2008

Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 5.6 per fly 8878 4-21-08 yt
State of Maryland 7 Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Lee Horsch Dion 5 April 2008 10:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months 2 K F Director 2498 Sept 9, 1941 44 Wisconsin Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show notified at 1 □ Yes 2 📆 No Director MD P.G. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or ? Examiner must be n 9537 Hale Drive 20735 United States death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evaminor 1 ☐ Yes 2 ▼ Your of Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No. Baltimore, Maryland 21215-0036 Specify. ģ Specify: White 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CVS Peoples Retail Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Newton Felt Irene S. Miller ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Millsaps (Daughter) 102 Patuxant Mobile Estates, Lothian, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) April, Pate, 200820c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Memorial Gardens Dunkirk, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral 200153 Alexandria Ferry Road, Clinton, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed burial-transit and Due to (or as a consequence of). P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1□Live birth 3 □Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hasl was an autopsy performed?
Ves 200 No this certificate 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient P 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Director: After Attending 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide ō within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) D006480 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Surratts Road, #307, Clinton, MD

20735

7501

32. Registrar's Signature

Bhabin Patel, M.D.

APR 0 8 2008

31. Date filed (Month, Day, Year)

6.00

10d. Inside City Limits

White

Day

Year

1 TYes XX

To the Hospital or Attending Physician: within 24 hours a

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVAQ 31. Date filed (Month, Day, Registrar's Signature State 2008 0 8 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Registrar
DHMH 17 Rev 1/2001

08-02572 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Horace Haire 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 1, 2008 0940 hrs Hair **Medical Examiner** orac 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death N 632 Cheraton Street **Baltimore** If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** oreign Months Days Hours Min. Director 214-66 Country) 66 1 M 2 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 Yes 2 No or 28n-f shov , or items 23a or 28n-f shor r must be notified at once Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14. Race - American Indian, Black. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married Yes 1 Yes 2 No specify: Specify: If Yes, Give Year 4 Divorced "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. Baltimore, MD 21215-0036 never worked 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Haire Dessie mal 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) heraton - COUSIN lh. McCormic 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial or other 2 Cremation 3 Removal from State 8-08 ausdown MT-2101 Department Important; Donation 5 Other Specify: permit. 22. Name and Address of Facility 70 injury 21. Sign sur of Funer V Service Ligensee Fred HILTU complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and fail r List only one cause on each line. /Medical Death Chronic Alcohol Abuse Imme inte Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical or use as the buriar X UNPENDED AMENDED 23a, 27 per ME g878 4/15/08 amh Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) this certificate has been signed by the attendirector, page 2 should be detached for 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) funeral 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27 Manner of Death Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 2, 2008 O.C.M.E. erson who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR O Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Mansour Hoghooghi April 2008 12:11 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7744 Chatfield Lane Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11–22–1927 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 F 265 85 7751 80 Iran Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. Counfy 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the M dical Examiner must be a 7744 Chatfield Lane 21043 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Judge State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Agha-Vali Hoghooghi Gohar unknown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael M. Hoghooghi/Son 3901 Sugarloaf Drive Austin, TX 78738 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State injury or Ardent Crematory 4-7-2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cancer zers GAHRIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed the burial-tran and Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical as 1 attending p for use as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 DEctopic pregnancy in the past 12 months? Month Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 📉 o 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has r 24a. Was an autopsy performed certificate 1 TYes 2 No 1∐ Yes 2☑ No or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 Pending To the Hospitai or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu M 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D33409 April 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HYIT, Lomelly My Falls Rd 21593 Shard m 12753 William 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr 9878 4-8-08 vt. State of Maryland 7 Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 03 Physician Desta T. Jima /Medical 4c. County of Death Facility Name. (If not institution, give street, and number) 4b City, Town, or Location of Death Examiner 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Hours Min 1□M 2√2F Yrs. ői 219-67-0593 60 11 Director Ethiopia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes & ☐ No Director MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 8030 Dalesford Road 21234 Ethiopia Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene. House Homemaker Unk 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gemja Teneyu Teddese Jima 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8030 Dalesford Road, Parkville, Md 21234 Alemensh Kassa-Daughter : If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Addis, Ababa permit. Page Department of Important: if any Injury or once. 4/14/08 St. Georgess Ethiopia March F/H West 21. Signature of Funeral Service Licenses Baltimore, 21215 4300 Wabash Ave, Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ENDOCARDITIS **Physician** /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine FIBRILLATION the Hospital or Attending Physician: The law requires that the death certificate be executed ATRIAL Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial FSRR Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe /es 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No i Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours afte To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESODO MD avalua 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BOULEVARD, BALTIMORE, MA SABAEVA ELENA. 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2008 APR 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 200^{Yea} **Physician** 3, 2:07 Рм Yvonne Carr Jackson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Greater Baltimore Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday Social Security Number **Funeral** 218-46-1672 1 □ M 2 XF 62 Aug. 2, 1945 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State ms 23a or 28a-f show must be notified at Monkton 1 ☐ Yes 2X No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21111 17437 Troyer Road or Items 23a Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2X Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. Specify: Black Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Lucent Technologies 2 years Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Lewis Johnson Emily Hall ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Charles W. Jackson/ Husband 17437 Troyer Rd. Monkton, Maryland 21111 Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4/12/08 Greenmount Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee Dro 5240 Reisterstown Rd. Baltimore, MD 21215 Tarres Part1. Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if y to all it immediates cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed?

1 Yes 2 No certificate or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one, funeral director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural To the within 24 hours are To the Funeral Director; reserved to the Funeral Director; reserved to the further filled in by the further further for the further 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

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State

31. Date filed (Month, Day,

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TECHARLES Street Ste 550 TOWSON, MD

em 23a)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау Month Year **Physician** Jacks Urail March 2053 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9—20—1970 Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 577-04-7601 1 M 2 □ F 37 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director MDBaltimore Randallstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 3546 Carriage Hill Circle, Apt. t4 211.33 LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2V No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Black altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) State Of Maryland Pages 1 and 2 should be filed withir thent of Health and Mental Hygiene.
 Tant: If item 27 is marked other than jury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk Comptroller's Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Savoy Caroline Jacks ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felicia Jacks/Wife 3546 Carriage Hill Circle, T4, Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Harmony Cemetery 4-7-08 Landover, MD 21. Sign Pre of Funeral Service Licenspe 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) 2 weeks /Medical Due to (or as a consequence of): Examiner Hodgkin's disease
Due to (of as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last 1 month Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 Other (specity) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2/2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Ange March RES-000 30,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H Angel Chan, M.D., The Johns Hopkins Hospital 600 North Wolfe Street, Baltimore, MD 21231 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6-15AM KIMMELMAN 04 APRIL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** `کر NORTH WEST HOSPITAL ZANDALL BALTIMORE 1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 06/25/3/3/927 6. Sex Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country)
 MD **Funeral** 1 M 2 K F Months 214-20-6806 80 MD **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified 1 XIVes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 7121 PARK HEIGHTS AVENUE, APT. 105 21215 USA death v Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Yes 2 X No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🛣 No ò 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY CATERING other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file tment of Health and Mental H-tant: If item 27 is marked out jury or other traumatic even Be ABRAMOWITZ LOUIS ROSE GREENBERG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY ABEL / SON 3200 KEYSER ROAD, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of important: If any injury or once. 4 □ Dopation 5 □ Other (Specify) BALTIMORE HEBREW 04/06/2008 REISTERSTOWN, MD 21. Sonature of Funeral Service Li SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complication, that caused to shock, or heart failure. List only one care on each line or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOMYOPATHY /Medical Due to (or as a consequence of): **Examiner** IZENAL FAILURE Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nunsequence of Examine The law requires that the death certificate be executed Due to (or as a consequence of) burial-Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No Probably 4 ☐Unknown Completed 24a. Was an autopsy performad? 1∐ Yes 2. No Were autopsy findings available prior to completion of cause of page 2 s has death? certificate 2□ No or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital: Inpatient 1 Tes 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760, 🥪 within 24 hours at To the Funeral C completely filled i To the Hospitai

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VENKATA 31. Date filed (Month, Day, Year) APR 0 8 2008

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IZEDDIVARI 32. Registrar's Signature

and manner stated

MD

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Vera A. Lenhart 5 April 2008 2:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Hours 217-24-2624 80 Director MAY 4 1927 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notifled at 1 ☐ Yes 2 No Director **Baltimore** Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 405 Westside Boulevard 21228 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married o, Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ģ 3 X Widowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) College (1-4or 5+) Tool Grinder Manufacturing and Mental Hygiv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Andrefsky Mary Senchek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trau Neil S. Lenhart - Son 405 Westside Boulevard, Catonsville, MD 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory, Inc. 4/7/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee
Steven H. Williams Name and Address of Facility Cremation Society of Maryland, Inc. - Huer 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BLADDER **Physician** IYR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician a for use as the burial Division or Vital Records, P.O. Box 68760 The law requires that the death certificate be Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ■ No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 27. Manner of Death 1 MNatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1425 BOLTON ST BACTIMORE, MD ZIZIF 0 , Day, Year) 32 Registrar's Signature

State Registrar

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## Section Section Control Protection Furnished Foundation State Foundation of Control Protection Furnished Control Protection Foundation of Control Protection Furnished Cont	ß,						3. Time of Death 5:35 P M
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOON S. YUN LCDR MC USN State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	on or	ding Phy th. : After this s funeral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work?		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOON S. YUN LCDR MC USN State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To th withir To th comp	Me			. A	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** THELMA V. LINDAMOOD APRIL 6, 3:39 P 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARITAS HOUSE ASSISTED LIVING BALTIMORE BALTIMORE CITY 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 ☐ M 2 🕅 F 96 Director 213-18-0571 1911 MARYLÁND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Ex miner must be notified at 1 X Yes 2 No MARYLAND BALTIMORE CITY Directo BALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1214 CLEVELAND STREET 21230 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: è 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TYPIST RETAIL STORE OFFICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUTHER CATTERTON ETTA HART 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY V. LEEMAN/ DAUGHTER 1819 NORFOLK RD., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State APRIL 11. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Ponation 5☐Other (Specify) LOUDON PARK CEMETERY 2008 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee Name and Address of Facility
RKLEY-RUDDICK
CRAIN HWY., FUNERAL HOME, P.A. S.E., GLEN BÜRNIE, MD 21061 23a. Part Lenter the Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician EMPS CARCINOM /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and the other and the for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐ Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? 1 Yes 2**X** No Hospital or Attending Physician: Was case referred examiner?
1 ☐ Yes 2 ☑ No Be Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) I IV I NG Hospital: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 8 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D19991 APRIL 7, 2008 ne and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

DAVID ROSE, M.D.,

APR 0 8 2008

31. Date filed (Month, Day, Year)

2. Registrar's Signature

200 HOSPITAL DRIVE, #421, GLEN BURNIE, MARYLAND 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department / Department	artment of Health and Mertificate of Death	ental Hygier	2000	11289
Ī	Physici	an	1. Decedent's Name (First, Middle, Last) Earnest Braxton Lo		2. Date of Death April 2,		3. Time of Death 1:25 Р м
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1,2J 1 M
	LAGIIII	CI	13103 Rhame Drive	Fort Washington		Prince Geo	rge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Yea	9. Birthola	ace (State or Foreign
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Maryland 21215-0036	C1 10 00 00	1		g Address <i>(Street and Number or Rural</i> 3 Rhame Drive, Fort			Code) 10744
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Baltimore,	(i) (i) h		1 Marial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Marial or	sition (Name of natory or other place) April 10	, 2008 Ch	eltenham,	*
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	the the the the the the the the the the	Med	one) and manner stated. 29b. Signature and title of €€ ritifier	29c. License number		Date signed (Month, D	
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	leti		30. Name and address of person who completed cause of death (Item 23a) (Type, P C VERGARA - SCARES 9940 FRANKLI) 31. Date filed (Month, Day, Year) APR 0 8 2008 32 Registrar's Signature	N SOUARE DR. NO	TTINGHAN	1, MD- 21	1236
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	Registr	ar	MIN V O COUL PERSON NO PERSON	450			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2008 27 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner atonsu Yas F etimore ille If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Number Funeral Months 1**⊠**M 2□ F 216-24-3601 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Wedical Exercitors must be notified at 1 □ Yes 2 200 Funeral Director ma. 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White. etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Yes. Give Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If Item 27 is
any injury or other trau 223 Melvin Apt.A Ave MD, 21228 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Star -3-08 4 □ Donation 2 5 □ Other (Specify) 22. Name and Address of Facility 270 21. Signatur of Funeral Service License FredHILTON 21229 P. march Fit. 23a. Part 1. 5 In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat 2 ause (Final disease or condition resulting in death) Physician 100 1.00 /Medical Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran requires that the death certificate be exec Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) P.O. I ed by the a detached fi 9 Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an After this certificate has page 2 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 □No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 21229

Registrar

State

31. Date filed (Month, Day, Year)

APR 0 8 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 1474M ANTHA 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1□M 2XF Yrs 245-78-3644 60 8-31-1947 NC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director M Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5525 Harpers Farm Road 21045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify African-American ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Howard County College Caterer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Lewis Mary Downey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gloria Lewis/Daughter P.O. Box 224, Stovall, NC 27582 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Lewis Chapel 4-12-08 Oxford, NC 4 Domation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Run 1.4. of 39 to. Co. ture of Funeral Service Licensee 9200 liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** feute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Physician/Medical the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 2 No funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death after death the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Division or Vital Records, P.O. Box 68760, Hospital or Attending completely filled in by within 24 hours a To the Funeral I 2

> State Registrar

3

29b. Signature and title of certifier

14/12 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0053051

Edan CANE, Colombia, Mi)

29d. Date signed (Month, Day, Year)

Registrar

2. Registrar's Signature

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Registrar

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ORIGINAL

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Physici	3 D	1. Decedent's Name								2	2. Date of De Month	eath Da	ay Year	3. Time	of Death
/Medic				Daisy	Mae		May				April		, 2008	4:4	O A ^M
Examin	er	4a. Facility Name (If	not institution, g	ive street and number)			4b. Cit		r Location	of Death			c. County of Dea		
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Funeral		5. Social Security N		Sex 7. Ag 1 ☐ M 2 ☑ F	e (In yrs. i	~	rs. Months		Hours	Min.	3. Date of Bi (Month, D	ay, Year	·) C	rthplace (Sta ountry)	
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To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier (Check only		Physician: To the best taminer: On the basis of											se(s)
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ίλ		30. Name and addr	ress of person wh	M.D., 1650	death (Iten	n 23a) (1	Type, Print)	m Jan	Balt	MOLE	Maral	and	21231		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 10:42 AV **Physician** GIORIA 2008 MICHAEL */Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and n Examiner Baltimore Medica Merce If Under Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛛 F Yrs. **Director** 220-36-0205 06-14-1940 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at ty⊠Yes 2 □ No Funeral Director MD Baltimore N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3318 Fait Avenue United States 21224 death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify.White ş 3 Widowed 4 Divorced natural" Completed 16a. Decedent's Usual Occupation of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carey Pollock Sara Rice 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wavne Michael Sr. (Husband 3318 Fait Avenue Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot Hilltop Service Corp. 04-08-2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk Inc. 7922 Wise Avenue Dundalk MD 21222 art1. Enter the diseas shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Pulmanan Diseas Obstrative Syeans **Physician** /Medical **Examiner** sepsus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine lor Attending Physician: The law requires that the death certificate be executed 15 that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 20 No Other: 2 ER/Outpatient 3 DOA Certification: To 1 TYes 1 Impatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident Director: 6 □Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

within 24 hours a To the Funeral C the Hospital 2

Registrar

29b. Signature and title of certifier

MD

address of person who completed cause of death (Item 23a) (Type, Print) ST. Val

. Registrar's Signature

29c. License number 056399

81.

29d. Date signed (Month, Day, Year)

Baltinere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 04/2008 Year **Physician** 5:30p.: DOROTHY E. MARTINEZ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE STELLA MARIS HOSPICE TIMONIUM 8. Date of Birth (Month, Day, Year) 04/29/1929 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 78 Director 215-24-4927 Usual Residence of Decedent MARYLAND permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No BALTIMORE PARKVILLE Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 1758 YAKONA ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOARD OF EDUCATION CAFETERIA EMPLOYEE Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN CERNIK MARIE STOLBA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8346 CYPRESS MILL ROAD NOTTINGHAM, MD 21236 DENNIS MARTINEZ/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition P □ Cremation 3 □ Removal from State 1 ☐ Burial METRO CREMATORY, INC. 4/5/2008 CATONSVILLE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility of Funeral Service Licenses 21. Signatur THE JOHNSON FUNERAL HOME P.A. LOCH RAVEN BLVD. TOWSON, MD 21286 Approximate Interval Between Onset and Death and. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) ays Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: Be မ Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. filled in by the funeral After after death Director: e Funeral

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Feltal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	Month Day Year		
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	Be. Did tobacco use contribute to the cause of death?		
		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
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27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work?	escribe how injury occurred		
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	1 28e. Place of injury - At nome, tairn, street, factory, onice 201. Lo	8f. Location (Street and Number or Rural Route Number, City or Town, State)		
	hysician: To the best of my knowledge, death occurred at the time, date and place, and du			

29c. License number

24d. Date signed (Month, Day, Year)

State

Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Ernestine Wright, 8909 Reisterstown Road Pickesville, MD MD

31. Date filed (Month, Day, Year) APR 0 8 2008

29b. Signature and title of certifier

within 24 hour To the Fune completely file

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month CONSTANCE MCGHER 2608 4:40 PM 6 MPVII /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital AIM City Ballimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | April 2, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 KF Pennsylvania 193-44-6589 54 1954 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits X Yes 2 No iral", or items 23a or 28a-f st Examiner must be notifled Completed by Funeral Director Arapahoe Centennial 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4393 E. Phillips Place 80122 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ KNo Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Consultant Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic ever Albert Creger Cathy McKernon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4393 E. Phillips Place, Centennial, CO 80122 Darrell McGregor - Husband 20b. Place of Disposition (Name of competent, crematory or other place)
West Arundel Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4-8-2008 Odenton, MD 4☐Donation 5.☐Other (Specify) Crematory 22. Name and Address of Facility Ambrose Funeral Home, Signature of Funeral Service Lic 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Mumoni month /Medical Due to (or as a consequence of): Examiner mmuno Suppression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -idney transplan attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Arter this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 6,2008 Res-000

10

State Registrar

30. Name and address of pe

31. Date filed (Month, Day, Year)

Johns Hopkins Hospital, 600 N. Wate Street, Baltimore, ND 21287

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

The

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	e of Maryland / Depa <i>Cer</i>	artment of He rtificate of D			ne . No. 2008	11298
Physic /Med		Decedent's Name (First, Middle, Last) M. Kathryn McCac	hren			2. Date of Death Month 23	, ^{Day} 2008 Year	3. Time of Death 9:50 PM
Exam		4a. Facility Name (If not institution, give street an Southern Maryland		4b. City, Town, or Lo	ocation of Death		4c. County of Dea	ath
Funera Directo		5. Social Security Number 6. Sex 1 M 2 M	F 83 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Young) Dec 18,	9. Bi 1924 Arr	rthplace (State or Foreign country) nagh, PA
ryland how lat		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
th the Ma or 28a-f s e notified	Funeral Director	MD P.G. 10e. Street and Number	Ca	mp Springs		10g	. Citizen of What C	1 □ Yes 2 TNO
eath wi	eral	5406 Mancheste			20746	ecify Ves or No.	USA 14. Race - Am	erican Indian
hours after datural", or item	by Fun	1 Never Married 2 Married 1 If Ye	res 2□No	Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2□ No	Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	Completed	15. Decedent's Education (Specify only highest grade completed in the complete state of	ge (1-4or 5+) (Give life. I	dent's Usual Occupati kind of work done dur DO NOT use retired)	ring most of worki	ng	b. Kind of Business	·
filled wi Hygien other th	Con	12 17. Father's Name (First, Middle, Last)	4 Re	t. Account		(First, Middle, Ma		ment Contract
ould be fill Mental H arked oth	To Be	Charles Milton	McCachren		I	Laura Bel	1 Smith	
d 2 shoth and the and traums		19a. Informant's Name/Relationship (Type. Print Robert S. McCachren (B		ng Address <i>(Street and</i> Buffalo R				* *
ages 1 and of the filter 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal	20b. Place of Dispo	sition (Name of natory or other place)			c. Location - City o	
permit. Pages Department of mportant: If it iny injury or one	200	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lious e	22	emetery Ap Name and Address	of FacilityLee	Funeral		6633 Old
00700		23a. Part 1. Enter the disease, or complications to	hat caused the death. Do not ent	exandria F er the mode of dying,				20735 Approximate
Physiciar /Medica		resulting in death)	erebrovascular	Accident				Interval Between Onset and Death Unknown
Examine		Sequentially list conditions	e to (or as a consequence of):	-				
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter U. derlying Cause (Disease or injury that initiated events.	e to (or as a consequence of):					
ficate be executed physician and is the burial-transit	edical Exa	that initiated events c c c d.	e to (or as a consequence of):					
ertificat ling phy e as the		IF FEMALE:	CUMENC -	· · · · · · · · · · · · · · · · · · ·				
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as it	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
v requires that been signed b	þ	Part II. Other significant conditions contributing Anemia	to death but not resulting in the ur	nderlying cause given	in Part I.		cco use contribute 2 □ No 3 □ F	to the cause of death? Probably 4 📆 Inknown
he law re has bee ge 2 sho	Completed	Atrial Fibrilation				24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
ian: Ti rtificate xtor, pa	a)	25. Was case referred to medical		2	26. Place of Death	1 Yes 2 (Check only one)	XNo 1 □ Ye	s 2 No
Physic this ce	To B		1 ∏Inpatient 2 ☐ ER/Outpatien		4 LI Nursing Ho	me 5 🗆 Residenc		ecify)
nding Fith. r: After e funera	tion:		Date of Injury 28b. Time of Month, Day Year) 1 Injury	Work?	es 2∐No	28d. Describe how	injury occurred	
al or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of injury - At home, farm, strouilding, etc. (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
ne Hospit n 24 hours ne Funera	edical C	(Check only 2 Medical Examiner: On	o the best of my knowledge, death he basis of examination and/or in manner stated.	n occurred at the time vestigation, in my opir	, date and place, nion, death occuri	and due to the caus red at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
To the within To the comp	ğ	29b. Signature and title of certifier	M.D.	29c. License n			Date signed (Mor	-
15		30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print)	3446		1.64	· · · · · · · · · · · · · · · · · · ·
1		Rointan Farahi-Far, N	I.D. 9801 Georgi Z. Registrar's Signature	a Ave #341	Silver,	Spring,	MD 20902	
S	tate	31. Date filed (Month, Day, Year)	la La	•0				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Phy G878 4/08/08 JH ifficate of Death Reg. No. 2. Date of Death 4-05-2008 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Month Day RACHEL MEEHAN 715PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL LAUREL HOSPITAL PRINCE GEOKGES AUREL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 1□M 2**√**F Months Days Hours Min 353-36-82 Director MAR. 30/915 Ont Usual Residence of De permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No **Funeral Director** Md PPER 750 RGE INCE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 A Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္ OR 19a. Informant's Nane/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) FRINE)/sun od of Disposition 1 Burial 2 ☐ Cremation 3 Removal fr 4 □ Donation 5 □ Other (Specify) 2008 21. Sign re Funeral Service Licensee からり、スタ +un,5 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resultatory arrest, Immediate Cause (Final diseases expense). TO Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SYNDROME 2120 /Medical Due to (or as a consequence of): Examiner INFECTION WOUND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed DECURITUS

Due to (or as a consequence of): that initiated events resulting in death) Last VLCER and Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy perform certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4454 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gar Thersbu 19001 alendoner Z ANTHI ANGANATHAN APR 0 7 31. Date filed (Month, Day, 32. Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per th 9878 4-9-08 vt. State of Marylane? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death give street and number, Examiner 4 nda DNIN If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day 915 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Hours Months Days 218-18-5079 1□M 2∏F 90 Director SOUTH CAROLINA 4-22-1917 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1XXYes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2101 RIDGEHILL AVE. 21217 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2⊠ No 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ Specify: BLACK 3₺Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE GAS & Elementary/Secondary (0-12) College (1-4or 5+) FILE CLERK ELECTRIC CO. -12-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIE GRAHAM ROBERT BAILEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGAREE FICKLING(DAUGHTER) 305 BIRKWOOD PLACE BALTIMORE, MARYLAND 21218 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL 4-11-2008 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee JONATHAN HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. P.n.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one course on each line. Imm diate Cause (Final **Physician** dise e or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has t 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 KER/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 4,2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 MUC atricia 1 ton 31. Date filed (Month, Day, Year) strar's Signature State

DHMH 17 Rev 1/2001

Registrar

Patient Kyrun as Jewel Martin

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f Vital	
Division o	

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			For State Registrar	State of M	arylan	•			Mental Hygie	ene nns	11301
						Cei	rtificate of	Death		. No.	10.7
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ا	Examin	er	11-11	Collins.			Baltic	<i>p</i> .	tra	N/A	
Fu	uneral			5. Sex 7. Ac		last birthday)	If Under 1 Year	If Under 24 Hrs Hours Min	8. Date of Birth	9. Bir	thplace (State or Foreign
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pur	≥ caro		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ecation				10d. Inside City Limits
Manyii	e p	5		TIMORE			BALTIMORE				1 ☐ Yes 2 💢 No
the	28a	rec	10e. Street and Number		1		10f. Zip Code		100	. Citizen of What C	ountry?
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deet	E E	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whi	
36 atte	or it	Y.F.	1 Never Married 2 Marrie	od 1 □ Yes 2 🕅	No	1	1 ☐ Yes 2 💢 No	Specify:	,,		WHITE
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and 2121 be filed within tal Hygiene.	vent,	Bec	17. Father's Name (First, Middle, L	ast)				18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
arylar should b	atic e	To E	LE0		FISHE	ER		AF	RLINE	MA	RKON
Maryland 21215-0036 nd 2 should be filed within 72 hours at! Ith and Mental Hygiene.	ortant: If item 27 is marked other than "naturel; or iteme 23s or 28s-f show injury or other traumatic event, the Madical Examinar must be notified at a.g	0	19a. Informant's Name/Relationshi				-		iural Route Number, (BALTIMORE,	•	
e, N 1 and Health	am 27 ther t	ļ	SHARON MARTIN 20a. Method of Disposition	/ DAUGHTER	20h P		F ELSA IE	KKACE, E		in ZIZI ic. Location - City or	
Baltimore, permit. Pages 1 at Department of Hea	1: H it		1 ABurial 2 ☐ Cremation		6	emetery, crei	natory or other plac				
Baltimo permit. Pag Department	ortani injury i.		4 Donation 5 Other (Sp. 21. Signature of Fungral Service Li	-A	_BF1		EMORIAL I 2. Name and Addre		O6/2008 R	ANDALLSTO	
Ba Per Depi	eny ir		Melinel	KAMAO ~	_						, MD 21208
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause	d the death						Approximate Interval Between
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/Me	edical		resulting in death)	Due to (or as	a conceq	uence of):		<u> </u>			101111100103
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Box eath cert	endin r use	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			∃Ectopic pregnancy	,		23d. Date of de	
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V requ	should I	Completed		Chriter			*		24a. Was an		
The iav	2 5	d L							autopsy perform	prior to death?	completion of cause of
ta I	or. pa		25. Was case referred to medical					26 Place of De	1 ☐ Yes 2 { eath (Check only one,	& No 1 L Ye	s No
of Vita Physician:	s cert	To Be	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 XInpati	ent 2 🗆	ER/Outpatie	nt 3□ DOA O#	00	Home 5 ☐ Residen	ce 6 □Other (Spe	ecify)
Division of Vital Records, i or Attending Physician: The law requires tater death.	ter th		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju	ıry	28b. Time o	f 28c. Injur	y at	28d. Describe how		
Vision Attending	or: A	catic	2 ☐ Accident investiga	ation			M 1□	Yes 2 □ No			
or Att	Direct n y	Certification:	3 Suicide 6 Could no 4 Homicide determin				reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
pitai	filled		29a. Certifier 1X Certifying	Physician: To the best	of my kno	wledge deat	h occurred at the ti	me date and nier	e and due to the cau	co(c) and manner a	e stated
Ho 24 h	• Fun etely	edical	(Check only 2 Medical E	xaminer: On the basis of and manner si	of examina	tion and/or in	vestigation, in my o	pinion, death occ	curred at the time, dat	e and place, and du	e to the cause(s)
Division To the Hospital or Attendit within 24 hours after death.	To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	1017			29c. Licens	-		I. Date signed (Mon	nth, Day, Year)
	1.		Sotre	MOSIX			RE	5-000	ATTACHER OF	April 3	2008
	34		30. Name and address of person w				Print)	S-000 Ballino,		\$	
			Satrayt Do	e, MD	Sin	cu Hes	pp) oti	Salhmo.	re		
	Sta Registr		31. Date filed (Month, Day, Year)	DD8	rars Signa	ture	age of				
.01	-1091511	ai	MINUUL	-		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:21 P M APRIL 2008 EVELYN MARK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 6503 PARK HEIGHTS AVE., APT. #2F BALTIMORE N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛚 F Months Days Hours 212-01-2178 **Director** Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f showing the Wedical Examination at 1 Yes 2 No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6503 PARK HEIGHTS AVE., APT. #2F USA 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No WHITE Specify: <u>چ</u> 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi th and Mental F 7 Is marked ott SAMUEL MARKEL RACHEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health a Item 27 Is REBECCA MARK / DAUGHTER 3916 W. STRATHMORE AVE., BALTIMORE, MD 21215 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Pages 1 ARCTRIGTON CYFIZUR permit. Pages Department of Important: If It any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/06/2008 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE congestive 1 / EADT **Physician** 1 CEUS /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed and I-transit ng physician ar as the burial-to Due to (or as a consequence of): O. Box 68760, Physician/Medical signed by the attending I I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL FALLURE DEMEDTIA 2 No 1 Tes 3 Probably 4 Unknown has been sign 2 should I Completed ANEMIN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed DIABETES MELLITUS 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of Certification: 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, page

> State Registrar

29b. Signature and title of certifier

Cooper 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MO



29c. License number

PARK HEIGHTS

29d. Date signed (Month, Day, Year)

BAUT. MD 212/5

6503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** BEVERLY **MYERS** APCIL 2003 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner INAI HOSPITCH CI Baltimore Bartimace N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Hours 1 □ M 2 🔏 F 212-01-6734 06/12/1929 78 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f showner must be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3409 FIELDING ROAD 21208 USA Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No WHITE Specify Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ε **MYERS** FLORENCE HOFFMAN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD POLLACK / COUSIN 3409 FIELDING ROAD, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BNAI ISRAEL CONG. 04/06/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 days Due to (or as a consequence of): Asplication preumonia Eequer tally list our differe, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Malleneur her MCROHL Due to (or as a consequence of) Completed by Medical Certification: To Be

/Medical Examiner and To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Division or Vital Records, P.O. Box 68760, ours after death.
neral Director; A within 24 hours a
To the Funeral I
completely filled

Baltimore, Maryland 21215-0036

POJ.K.C. Myers BENETH

	d								
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3 ☐ Ectopic pre			23d. Date of delivery Month Day Year				
art II. Other significant conditions	contributing to death but not res	ulting in the underlying ca	use given in Part I.	23e. Did tobacc	o use contribute to the cause of death?				
Hypelkinsion				1 ☐ Yes	2 No 3 Probably 4 √ Unknown				
Dementic of	Alzheimi	Type		24a. Was an autopsy performed?					
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2 I	ER/Outpatient 3 □ DO	A Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)				
7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred				
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factory	office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)				
	hysician: To the best of my knominer: On the basis of examination and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)				

29c. License number

Sinal Harrier of Ballimero

RES-CCC

29d. Date signed (Month, Day, Year)

April, 4, 2008

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

APR 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.

8²2008

HANED

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year) Month **Physician** meyer 2008 ADri ary irainia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Be Air If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Harford enter Lucsina orien Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. 220 34 yr 3770 ber **Funeral** 1 □ M 200 F 98 Yrs. -34-5770 Director March 15 1910 Mary Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates: 21015 SA or items 23a onne by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Casualties Maryland 12 18. Mother's Name (First, Middle, Maiden Symame) 17. Father's Name (First, Middle, Last) Be SSac 10m1100 renda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 zabeth 1407 Bonne MD 21015 Date 21 other Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of I-Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8 rorest Evans Funeral Chapel-Bolltin 4 * 4 ☐ Donation 5 ☐ Other (Specify) Forgst Hill, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barlota Simblelle 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

Immediate Cause (Final) Evans Funeral Chasely Comation Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year detached for 4□Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 □ Yes 2 🖳 No of Vital filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Division 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide To the Hospitat o within 24 hours aff To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD ten 2008 045344 04/07 Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH DHANJANI 40 622 S.UNION AVE, HAVREDE GRACE, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ARTHA FFERMAN Most 830 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 058-09-7062 89 AUG 11 1918 New York Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 X No MD Queen Annes Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Orchestra Place 21617 USA 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary United Church of Christ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Asklof Lawrence A. Martha E. Sauter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert S. Offerman - Son 205 Orchestra Place, Centreville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State Metro Crematory, Inc. 4/4/2008 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Leaven H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or 5 squartially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical

Physician /Medical Examiner

attending physician

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certificate has

After

after death.

within 24 hours a To the Funerel [

injury or permit. Page Department of Important: If eny injury or once.

Physician

/Medical

Examiner

Director

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Funeral

Director

item 27 is marked other then "natural", or iteme 23a or 28a-f ebov other traumatic event, the Medical Exam, an must be inclined at

e tiled within 72 hours after if Hygiene. other then "natural", or ite

Pages 1 and 2 should be till ment of Health and Mental Hisnt: If item 27 is marked out

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Physician:

To the Hospital or Attending

with the Maryland **work**

death \

Physician/Medical þ Completed

Examiner burial-transit use es the for detached 2 Certification:

cal

23b. Was decedent pregnant

28d. Describe how injury occurred

26. Place of Death Check only one Cther: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

examiner'

5 Pending investigation 6 Could not be determined

1 patient 28a. Date of Injury (Month, Day Year)

Hospital:

2 ER/Outpatient 3 DOA 28b. Time of М

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier and

8008

29c. License number

EWSE

29d Date signed (Month, Day, Year)

wh rempleted cause of death (Item 23a) (Ty

445 Registrar's Sign

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State Registrar

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Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		3(a) 1- For State Registrar	e or iviaryiano /	-	ificate of D		na ivienta		eg. No. 20	108 1130
Physici Medical Exam	an/	1. Decedent's Name (First, Middle,t JANE FRAN		NEILI				2. Date of Dea Month	th Day Year	3. Time of Death 2207 hrs
ake 1994.		4a. Facility Name (if not institution,	give street and number)			City, Town,	or Location of	April 4, 20 Death	4c. County of	
Funeral		Good Samaritan Hospita 5. Social Security Number 6.		(In vrs. las		altimore f Under 1 Ye	ear If Under	24Hrs 8 Date of Bit	+b(AAM/DD 00000)	Birthplace (State or
Director		220 48 2952 1	M 2 X F	60	· · ·	Months Da		Min. 4/10/		Foreign Country) MD
any		Usual Residence of Decedent 10a. State 10b. County		Oc. City, T	own or Location					10d. Inside City Limits
Aaryland 28a-f show 1 at once.	tor	MD BALTII	MORE		ROSEDA					1 Yes 2 X No
with the Maryland is 23a or 28a-f sho e notified at once.	Director	10e. Street and Number 7911 SHIRLEY	AVENUE		10	of. Zip Code 2123	37	1	0g. Citizen of What	at Country?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marri		ver in U.S				n? (Specify Yes or No Puerto Rican, etc.)	14. Race - White,	- American Indian, Black, , etc.
rs after ural", o miner r	þ	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year		1 Ye		lo specify:	ad at most, done	Specify:	WHITE
2 " 🗔	leted	Elementary/Secondary (0-12)	College (1-4 or 5-		during most	of working li	fe. DO NOT us	se retired)	16b. Kind of Bus	iness/industry
5-0036 ed within 72 tygiene. other than "	Completed	12 17. Father's Name (First, Middle, La	0		HOM	EMAKE		Name (First Middle)	OWN H	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	FRANK A.	SKINNER	SR.				Name (First, Middle, RY JANE	DeSTEI	
MD 21 rd 2 should olth and Me m 27 is ma	70	19a. Informant's Name/Relationship NANCY SKINNER						er or Rural Route Nur		
- E 6 5 - L		20a. Method of Disposition			ace of Disposition	(Name of c		Date		ORE, MD 2120 City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		1 Burial 2 Cremation 4 Donation 5 Other Spec	ify:		LAWN	CEMET	100000000000000000000000000000000000000	4/9/08	BALTIM	MORE, MD
Balt permit. Depart Impor injury		21. Signature of Funeral Service Like	sensee		22. Nam			CVACH/RO AVE BALT		FUNERAL HOM
Physician /Medical		23a. Part I. Enter the isease, or co failure. List only one cause on		he death. D			g, such as car	diac or respiratory arr	est, shock, or hea	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec			stage re	nal diseas	е		Death
- / -	_	Sequentially list conditions,	b							
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consec							1
executed an and al - transit		events resulting in death) Last	cDue to (or as a consected	(uence ot):						
760, icate be executed physician and the burial - transit	Medical				perME.,G8	78,4/8,	/08,WS			
5876 rtificate ling phy		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		2 Fetal o	leath 3	Ectopic p	pregnancy	23d. Date of o Month	delivery Day Year
Box 687 ne death certific referending perference on the	Physician/	1 Yes 2 ✔ No 9 Unkno	4 Pregnant at ti wn g Unknown	me of deat	h 5 Other	(Specify)				
, P.O. Erres that the designed by the		Part II. Other significant condition				rlying cause	given in Part			bute to the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the fine of the page 2 should be a set of the funeral director.	Certification:	3 Suicide 6 ✔ Could n	ot be 28e. Place of Inju	-		ctory, office	building, etc.	or Town, S		er or Rural Route Number, City
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the complete of the control of the		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge	, death occurred			e, and due to the caus	se(s) and manner	as stated.
To the within To the comp	Medical	29b. Signature and title of certifier	and manner stated.							ed (Month, Day, Year)
		Jans	ezni	>		0.0	.M.E.		April 5, 200	8
10	1	30. Name and address of person wh Tasha Greenberg MD.	o complete cause of dea Assistant Medical	,	•	nn Street	. Baltimore	e, MD 21201	Contract of the Contract of th	
St	ate	31. Date filed (Marp 19ay) e8) 2	Assistant riedical				, Damilole	.,		
Regist	rar	13111000		-						

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month **Physician** 6:01 A^M Creiq Franklin Petzold April 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7825 Windrow Court Elkridge Howard 8. Date of Birth (Month, Day, Ye Aug. 9, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min. 047-68-2654 55 Director 1952 California Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show must be notified 1 ☐ Yes 2 No Director MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21075 7825 Windrow Ct. U.S.A. 23a Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Medical Examiner Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: White Specify þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) owner/operator HVAC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert H. Petzold Juanita Stringham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Karl C. Petzold/Son 7528 Windrow Ct. Elkridge MD 21075 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 4-4-08 Odenton, Maryland Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) (ach Physician Minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the signed by Pan II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 2 Accident 5 Pending investigation Injury ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor

To the Fune (Check only and manner stated To the I 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. Michael Silverman,

31. Date filed (Month, Day, Year) APR 0 8 2008

29c. License number

11085 Little Patuxent Pkwy, #101, Columbia, MD 21044

29d. Date signed (Month, Day, Year)

7008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 5, 2008 Year Alee Ernestine Porter 3:40 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 226 56 5951 62 Virignia July 8, 1945 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2□No Maryland Prince George's Camp Springs, 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5608 Gloria Drive 20746 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 ♥ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ret. Clerical/ Secretary Verizon (AT&T) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phillip Hary Copeland Gusteen Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elma Brandon (Sister in law) 7338 Denton Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State April 14, 2008 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery | One Leman, July 100, 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Lice of ee Alexandria Ferry Road, Clinton, MD 20735 le 40015 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEP HEPATIC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last liver dispase Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2**X**2No 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

be execu

Box 68760,

P.O. I

Division or Vital Records,

Physician:

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To the Hospital o within 24 hours aff To the Funeral D completely filled in

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any Injury or other trau

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filed within 72 hours after death with

Baltimore, Maryland 21215-0036

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Examine and attending physician Physician/Medical signed by the a \$ been si Completed certificate has funeral director, Be this (10 Certification: After spital or Attendi iours after death. neral Director: A

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 5 Pending

29a. Certifier

(Check only one)

investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 10033215 29d. Date signed (Month, Day, Year) 08

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State Registrar

Medical

MD: 11701 Livingston Rd Ste 203- FT. WASHINGTON, MD 20744

Registrar's Signifure

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			1 - State Registrar	State of Maryland / Depa	artment of Health and N rtificate of Death	Mental Hygier Reg. h					
*	Physici		1. Decedent's Name (First, Middle, Last Mable	Perry		2. Date of Death Month	Nay Year 3. Time of Death				
Apple 1	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give 6906 Walded 5. Social Security Number 578 36 9734 6. Se	Avenue	4b. City, Town, or Location of Death Comp Spring If Under 1 Year Under 24 Uss. Months Days Hours Min.	8. Date of Birth	4c. County of Death 9. Birthplace (State or Foreign Country) 910 South Carolina				
	h the Maryland ir 28e-f show	irector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G 10e. Street and Number		ills		10d. Inside City Limits 1 ☐ Yes 2 ☐ No Citizen of What Country?				
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-f show or other treumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	6906 Waldran 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	20748 Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	United States 14. Race - American Indian, Black, White, etc. Specify: Black				
Maryland 21215-0036	filed within 72 Hygiene. Hygiene. other than "natu	Complete	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 8th 17. Father's Name (First, Middle, Last)	(Give life. College (1-4or 5+)	Jent's Usual Occupation kind of work done during most of wor. DO NOT use retired) Stic Worker 18. Mother's Nan	king	Nind of Business/Industry Domestic Services an Surmame)				
arylan	should be ind Mental marked o	To Be	Tom Minnick 19a. Informant's Name/Relationship (7)			ohie Danie	els				
ore, M	Pages 1 and 2 sent of Health arent of Health arent: If item 27 is	Robin Spriggs (Daughter) 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State Robin Spriggs (Daughter) 6906 Waldran Ave, Temple Hills, MD 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City									
Baltimore,	permit. Page Department Importent: If any Injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Lincoln 22	Cemetery April 5 R. Name and Address of Facility Lee Lexandria Ferry R	Funeral H	lome.Inc 6633 01d				
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)	To wit		29b. Signature and title of certifier	glight to	29c. License number	/	Date signed (Month, Day, Year) Dail 7 2008				
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Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Stre	eet and Number o	r Rural Route Numbe	er, City or Town, State, Zi	p Code)
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	1		30. Name and address of person who	completed cause of death (Ite	m 23a) /Tune 1				7. 6 3/20	
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DHMH 17 Rev 1/2001

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	Dhysisi		1. Decedent's Name (First, Middle, L	ast)					2. Date of D Month	eath Day	y Yeer	3. Time of Death
	Physici /Medi		JOAN BY	55ET	TI				04	0	5 2009	30530
	Examir		4a. Facility Name (If not institution, ga	ve street and number)			4b. City, Town, o	r Location of Dear	h	40.	County of Deatl	
			BAYVIEW	CAUSE ((L)	TER	BALT	Moss		t		DEE CITI
	Funeral Director		5. Social Security Number 6. 214-30-4018	Sex 7. Ag 1□ M 2⁄2 73		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			1	nplace (State or Foreign [*] untry) rland
	P.		Usual Residence of Decedent		10.00	-						
	arylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Ne M	ecto	MD Baltim	ore	Edge	emere				40.000		1 ☐ Yes 2☐No
	with th	Dir	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Co	intry?
	s 23	eral	24 Thomas Lane	12. Was Decedent	Ever in 11	C 12	21219	licennia Origin? /9	Specify Vec or N		ed State	
20	s after d	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 1 If Yes, Give	•		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	to Rican, etc.)		Black, White	e, etc.
21212-0030	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or Items 23a or 28a-f show evant, the Medical Examerations in the Leanth at	Completed b	15. Decedent's I	Year or Dates:		16a. Dece	dent's Usual Occup	ation	rking	16b. Ki	ind of Business/l	
Ž		nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	during most of wo	rking			
		Con	12	2		Homema	aker			Own Home		
Maryland	m - 0 2	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Na	me (First, Middl	e, Maiden	Sumame)	
<u>X</u>	should be ind Menta inarked marked	ဥ	Frederick Stout			_		Leona Ma				
a	S a a		19a. Informant's Name/Relationship		- ·		ng Address (Street			-	or Town, State, Z	ip Code)
_	s 1 and f Health ftem 27 other to		Carl D. Rosetti S	r. (Husba		_	nomas Lan	e Eageme	re MD 2		i Oib	C1-1-
Baltimore,	0 0		20a. Method of Disposition 1		0	emetery, crei	cemetery	04-0	8-2008		cation - City or timore,	
a a	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	ensee		22	2. Name and Addre	ss of Facility Du	da-Ruck	Fune	eral Hom	e of Dundal
n	89789		Justa G	Jener		Ir	nc. 7922	Wise Ave	nue Dun	dalk	Marylan	d 21222
			23a. art1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each li	d the death	n. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEP	SIS							Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseq	uence of):						
	Examiner		Sequentially list conditions.	b. 6001	10-0	1lipx	ily in	ection)			
1	po ți	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):	60 11	0 01 1-				
7	sician and burial-transit	cam	that initiated events resulting in death) Last	c. Phe Due to (or as	um	4701-	D HOST	hritis				
Ď.	be ex cian ourial			Due to (or as	a consequ	uerice or).						
58/6N,	the the	Aedical		d								
	certific iding p		IF FEMALE:	23c. If yes, outcome	of pregna	incv				1.	23d. Date of deli	v02/
õ	death ce e attendii id for use	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	ideath 3□	Ectopic pregnancy Other (specify)	′			Month Month	Day Year
j.	at the death cert by the attending stached for use	ıysi	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown			5 0 mor (0p30my)					
Ţ	E 8 8	by Physiclan/N	Part II. Other significant conditions	contributing to death b	out not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
ds,	w requires been signe should be								1	Yes 2	□No 3□Pro	bably 4 onknown
Record	> 0 10	Completed							24a. Wa	s an	24b. Were au	topsy findings available
E T	9 4 9	mc							aut	opsy ormed?	prior to death?	ompletion of cause of
Vital	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical					Ge Blace of Do	1 Yes		1 L Yes	2□ No
	Physician: this certific ral director,	OB	examiner?	Hospital: 1 Dippatie	ent 2 🗆	ER/Outpatier	it 3□ DOA Oth	er: 4 Chlursing I			6 ☐Other (Spec	1164)
ō	g Phy er this eral c	 	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of			28d. Describe			ny)
5	Attending In death. ector: After by the funer	atlo	1 Satural 5 Pending 2 Accident investigation		y rear)	Injury		k? Yes 2 □ No				
UINISION	al or Attendi atter death. I Director: A d in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of in	iury - At ho	ome, farm, str	eet, factory, office					ral Route Number,
5	ē ji tiệ c	Certification:	4 I HOINCIGE	building, ei	с. (Брөсп)	/)			City of 10	own, State	3)	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 Certifying F (Check only one)	hysician: To the best miner: On the basis o and manner st	f examina	wledge, deatl tion and/or in	occurred at the tirvestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s) , date and) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1	+LICII	7	29c. Licens	e number		29d. Dat	te signed (Month	, Day, Year)
	F > F 0		DA 12: ()	11.05	- AR	BAJE,	mo .0 /	so il		4.	-< -0	
	6		30. Name and address of person who	completed cause of	leath (Item	1 23a) (Tyne	Print) 4940	Eastern	Ave. Toh	ns H	opkins	Bayview Med
	2		ALICIA A	RBAFE.	M	D		more, Ma		212	_	ctr.
	Sta	tė	31. Date filed (Month, Day, Year)	2. Registr	ar's Signa	ture			<i>x</i>			
	Registi		APR 0 8 20	08 Blown	, di	Spa	de la					
DH	MH 17 Rev 1/2	001				9						

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month . 027PM Rhine 2008 April 4c. County of Death 4a. Facility Name (If not institution, give street and number) Johns Flopkins Bayulew | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | (Month, Day, Year) | November 27, 1923 5. Social Security Number Birthplace (State or Foreign Country) 1 □ M 2 🛣 303-24-2992 84 Michigan Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 TYes 2 No Dundalk Maryland Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 2902 Dunmore Road Apt D. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 💆 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Banking 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leonard Duston Helen Miller 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2902 Dunmore Road, Apt D. Dundalk, MD. 21222 Barbara Singh Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Oak Lawn Cemetery 2008 Dundalk, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Failure Respiratory Due to (or as a consequence of): 10 hours Intracraniou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician /Medical Examiner

item 27 is marked other traumatic ev

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Department of Important: If any injury or once,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f sh notified

ns 23a or 2 must be n

Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

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burial-tran Physician/Medical 2 To Be Completed within 24 hours after death

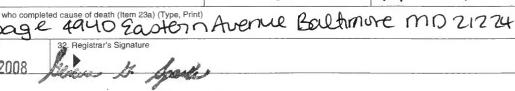
To the Funeral Director: A completely filled in by the f

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	d.	querice or).			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	33c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	al death 3□Ectop	oic pregnancy r (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlyi	ng cause given in Part I.		co use contribute to the cause of death 2 No 3 □ Probably 4 □ Unkr
				24a. Was an autopsy performed	
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ✓ 0	Hospital: 1 Mnpatient 2□	ER/Outpatient 3	Other	eath (Check only one) Home 5□ Residence	e 6 ⊟Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory)	ctory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	sician: To the best of my knoner: On the basis of examinated and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	P		29c. License number RES - 0 0 1	O 29d.	pril 3, 2008

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Month 200 Beatrice L. Rusen 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Samarita If Under 24 Hrs. (In yrs. 79 Birthplace (State or Foreign Country) 6. Sex last birthday) If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 💥 □ F Vrs Md. 3-25-1929 Director 220-20-6655 Usual Residence of Decedent death with the Maryland 10c. Cify, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show 1 □Yes 2 □No la or 28a-f sh Funeral Director Balto. Co. Md. Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 USA 1016 Valewood Rd. permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If tem 27 is marked other the any Injury or other traumation. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify White þ Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Glass & Paint Industry <u>Office Manager</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Raine Howard Amersbach 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 Valewood Rd. Towson Md. 21286 Janet L. Hale Dtr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-1-2008 Balto. Md. Gardens of Faith 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injurthat initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, nding physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 mooths? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ,2<u>∏</u> № 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 27. Manny of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After (Month, Day Year) 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 😨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier touter mD

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed Month, Day, Year)

APR 0 8

30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print)

560

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 2008 6, Sandra R. Stubbs 4:56 P™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 2041 Horseshoe Circle Jessup If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yea **Funeral** 1 □ M 2 XF Months Days Hours 61 Yrs. 583-09-0917 1946 Puerto Rico Director 10, Dec Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Jessup Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20794 2041 Horseshoe Circle USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Maryland 21215-0036 iXiyes 2□No *Specify:*Puerto Rican Specify: Hispanic <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth Be Jose Antonio Rivera Carman Victoria Vazquez - Bague 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2041 Horseshoe Circle Jessup, Maryland 20794 Nanette Muffley, Daughter item 27 other t Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Department of Important: If it any Injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 04/07/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Litensee
Thomas Gregor 22. Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 Ta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy perform certificate 2XINo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Hospital or Attending 5 Pending investigation 1 K Natural within 24 hours after uccome.

To the Funeral Director: After a second to the funeral process. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Da

Edward J. Lee MD 11065

0

Day,

29c. License number

Little Patuxent Parkway Columbia, Maryland 21044

29d. Date signed (Month, Day, Year)

1,2008

and manner stated.

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day 0742 M Axil Schlicht 2008 **Physician** orothu /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner tor Med Chroa 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) sec 8. Date of Birth (Month, Day, Year) If Under 1 Tast birthday, 7. Age (In yrs. Social Security Number Min. Hours Months Days **Funeral** 1□M 2 F 2 Baltimore ML) Yrs. 12. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10a. State 10b. County show 1 ☐ Yes 2 📉 No items 23a or 28a-f showner must be notified at Forest MD Directo Has 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 2304 60 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 Yes 20 No
If Yes, Give Year or Dates: Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be larc ပ္ 19b. Mailing Address (Street and Nymber or Jural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore, 20a. Method of Disposition 3 ☐Removal from State 1 Burial 2 □ Cremation 4 Donation 5 Dother (Specify) 22. Name and Address of Facility of OZOIS CIM Forest. 21. Signature of Funeral Service License 14 Crema Kinber 10 1 Frans Funcial Par1. Enter the diseast, of complication, that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Se 16 days Immediate Cause (Final OSI'S **Physician** disease or condition resulting in death) Due to (or s a consequence of): /Medical Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death Box (23b. Was decedent pregnant Year 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached formpletely filled in by the funeral director, page 2. 9□Unknown Division or Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25√No 24a. Was an autopsy performe 2/ No 1□ Yes 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA Inpatient 1 Tyes Medical Certification: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death Injury 5 ☐ Pending Natural 1 TYes 2 🗆 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D60768 MI Drive, Bel Air, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print);

M. Jokhalaw 500 Upper Chesapeake

DHMH 17 Rev 1/2001

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State Registrar Jokhadav

31. Date filed (Month, Day, Year)

8004331

Jorsthy

32 Registrar's Signature

Physician

/Medical

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIFM: 24a, perPHYS. C878, 478708 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year 3:45 am Olivia A. Stewart 2008 MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A OF BALTIMORE SIMAI HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1□M 2√F 217-50-9263 60 July 20, 1947 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count 1 □Yes 2 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4061 St. Johns Lane 21042 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Administration 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert R. Gibson Dorothy Kitchen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Stewart, Sr./Husband 4061 St. Johns Lane Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Greenmount Cemetery 4/2/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun ral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence failure 1 day metastatic disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Unc Breast Cancer months Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2X No `Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ni Keilner RES 000 MBBS March, 29, 2008

State Registrar

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P.O.

Division or Vital Records,

31. Date filed (Month, Day, Year)

SRIRATHA KOMERU, MBBS, SIMAI HOSPITAL OF BALTIMORE, 24 OI W. BELVEDERE AVE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

BALTIMORE, MD2125

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

indie Simmons	1	- For State	•	ent of Health and Mental ate of Death		200	3				
Div. isi	_6	Registrar 1. Decedent's Name (First, Middle,Last)	Oer tillo	ato OI Death	Reg.		3. Time of Death				
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		Andre 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of De		4c. County of Death					
		Good Samaritan Hospital		Baltimore							
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last bir	thday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birth Foreign					
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with the Maryland ms 23a or 28a-f sho be notified at once	ב <u>ֿ</u>	1442 Meredine Drive		21239		U.S.A.					
No 13 23.	<u>.</u>	11. Marital Status 12. Was Decedent	Ever in U.S.	13. Was Decedent of Hispanic Origin?		14. Race - Americ	an Indian, Black,				
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after of	<u>`</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2 X No specify:			.ack				
215-0036 he filed within 72 hours after death ntal Hygiene rked other than "natural", or ite ent, the Medical Examiner must		15. Decedent's Education (Specify only highest grade com-	,	Decedent's Usual Occupation (Give kind during most of working life, DO NOT use		16b. Kind of Business/Ir	ndustry				
127 n 721 ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5	5+)		,	Schoo	\1				
withi withi giene.	ĒL	4th grade na 17. Father's Name (First, Middle, Last)		Student	ame (First, Middle, Ma						
filed if Hyg		Andre Simmons Sr.			ame (First, Middle, Ma e Parrin	alderi Surilailie)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	9 0	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Address (Street and Number	or Rural Route Numb	er, City or Town, State.	Zip Code)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	-	Denise Simmons-Mother	1.3	bb. Mailing Address (Street and Number L442 Meredine Dr	, Baltim	ore, Md	21239				
e, N l and : Health item :	1	20a. Method of Disposition		of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State				
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Ba Perm Depz Impe	I	Elima Box. la		22. Name and Address of Facility March F/H West 4300 Wabash Av	: re, Balti	more, Md	21215				
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/Medical		failure. List only one cause on each line.									
xaminer		Immediate Cause (Final disease or condition resulting in death) a Cardiac arrhythmia Due to (or as a consequence of):									
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ox eath c atten for us	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	time of death	5 Other (Specify)							
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director.	and place, and due to th	e cause(s)									
To To Sor	29d. Date signed (Mo	nth, Day, Year)									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Mor. O.C.M.E. April 3, 2008											
	ŀ	30. Name and address of person who completed cause of o	eath (Item 23a)								
		Zabiullah Ali, M.D. Assistant Medical Ex		11 Penn Street, Baltimore, MD	21201						
Stat	te		r's Signature								
Registra		APR 0 8 2008	yes St.	Agree	OCME						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a per dr., 8878,04/08/08dhb

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 08 10:43 A.M 4 ohn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore-Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Director 216-42-4304 62 29, 1945 Maryland Dec. Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes % No Maryland Anne Arundel Glen Burnie Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be 7677 Harlow Drive Apt. 21061 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced "natural" Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Chief of Security HealthCare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry C. Spivey Geraldine V. Bahr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10308 Malcolm Circle Apt. B Cockeysville, MD 21030 John F. Spivey, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) April Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2008 Catonsville, MD of Funeral Service Licenses 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P. A.
421 Crain Hwy. S.E. Glen Burnie, MD 21061 21. Signatu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be c Completed by rhos 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed? Yes 2 No 1□ Yes 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: Hospital: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 1 Inpatient Certification: To funeral 27. Manner of Death 1∰Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 33296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie Quanter RD 711 31. Date filed (Month, Day, Year) APR 0 8 2008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State amend #10b Per FH	G878 4/0	2 08 if the control of the all in the control of	and Mental Hyt h	Reg. No.	11320
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	/Medic	al	4a. Facility Name (If no institution, give street and number	Kan	4b. City, Town, or Location	n of Death	4c. County of Death	5:30 PM
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Jan Sale			Usual Residence of Decedent	10c. City, Town	n or Location	110		10d, Inside City Limits
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0036	should be filed within 72 hours after death with the Maryland and Mental lygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Date:		1 ☐ Yes 2 1 No Specia	ry:	Specify: A	SIAN
7.	nin 72 l n "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)		Decedent's Usual Occupation (Give kind of work done during me life. DO NOT use retired)	ost of working	16b. Kind of Business/In	
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and	d be fill ental H ced ott	9 Be	17. Father's Name (First, Middle, Last)		18. Mot	ther's Name (First, Middle,	Maiden Surname)	hanh
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical ione.		20a. Method of Disposition 1 ☐ Burial 2 16 Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	cemete	f Disposition (Name of ry, crematory or other place)	4-4-2008	R. II v	owii, State
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Spro	w requires that the d been signed by the should be detached	ted b				10	Yes 2 No 3 Pro	bably 4 Unknown
Sec.	has be	Completed				24a. Was	an 24b. Were aut prior to co	opsy findings available ompletion of cause of
Cycle Ital		Be Co	25. Was case referred to medical		26. Pla	1 Yes	2 No 1 □ Yes	2 □ No
Chueng Tran Division or Vital Records,	Attending Physician: r death ector: After this certifics by the funeral director, I	To B	examiner? 1 Yes No Hospital: 1 Inpa		utpatient 3 DOA Other: 4	Nursing Home 5 ☐ Resi	dence 6 Other (Special	ity) Hospice
e e	iding Phys h After this funeral di	tion:	27. Manner of Death 1 Autural 5 Pending 2 Accident investigation 28a. Date of light (Month, light)		Time of 28c. Injury at Work? M 1 ☐ Yes 2		how injury occurred	٧
Visi	r Atten er deat rector by the	Certification:	3 Suicide 6 Could not be 28e. Place of	injury - At home, fa etc. (Specify)	ırm, street, factory, office	28f. Location (S	Street and Number or Rui vn, State)	ral Route Number,
ā	Hospital or 24 hours afte Funeral of tely filled n		29a. Certifier Certifying Physician: To the be		doath accurred at the time, date			etatad
	To the Hospital or Attending I within 24 hours after death To the Funeral Mrector: After completely filled in by the funer	Medical	(Check only one) 2 Medical Examiner: On the basis and manner	s of examination an				
	Mithii To th	ž	29b. Signature and title of pertition	MD	29c. License numbe	- Q 7	29d. Date signed (Month	, Day, Year)
	\wedge	1/4	30. Name and address of error who complete cause of	of death (Item 23a)	(Pyroe, Rrint)	7 11	ATICIC!	6000
	1	L.J.	Paul Gormley	4000	aton Ave	Softmo	ve mo	21229
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regi	istrar's Signature	Road 1			ŕ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene James Tucker Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 30, 2008 0320 hrs Examiner James H. Tucker, Sr.

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3900 Benzinger Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 224-70-8224 Director 02-25-1951 1 X M 2 57 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County 1 X Yes 2 No N/A Baltimore MD altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hours after death with the Maryland
spartment of Health and Mental Hygiene.
sportment of Health and Mental Hygiene.
sportment of I item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21229 USA 3900 Benzinger Rd. Apt. 261 23a noti 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) item 27 is marked other than "natural", or items traumatic event, the Medical Examiner must be White, etc. Armed Forces 1 Never Married 2 X Married Yes Specify: White Yes 2 X No specify: If Yes. Give Year Widowed Divorced 5 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction Door Maker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Lin Tucker Loretta Hoke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD. 21229 3900 Benzinger Rd. Baltimore. April Webb, daughter Apt. 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 20b. Place of Disposition (Name of cemetery crematory or other place) West or other Burial Removal from State 4-4-2008 Odenton Arundel C<u>rematory</u> Donation 5 Other Specify. 21. a ure of Funeral Service Licensee . 22. Name and Address of Facility. Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbitus.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follows. It is to be a cardiac or respiratory arrest, shock, or heart follows. Approximate Interval Between Onset and ysician failure. List only one cause on each line. Death **Aedica** a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **≟**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed Physician/Medical AMENDED UNPENDED ending physician use as the burial certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Month Dav 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown þ Chronic alcohol use Completed 24a. Was an 24b. Were autopsy findings available has been s prior to completion of cause of death? performed? 2 No ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) fo the Hospital or Attending Physician; 25. Was case referred to medical Division of Vital Be Hospital: 1 examiner? Other [Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 V Natural n 24 hours after death. le Funeral Director; ≜ letely filled in by the fu Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the F and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 30, 2008 O.C.M.E. CIMP 30. Name and address of person who com the ted cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

Cortificate of Death

			For State Registrar	State of Mar		ertificate of L			ene 0 0	8 11322
	Physici	an	1. Decedent's Name (First, Middle, Las				2	2. Date of Death Month	Day V	3. Time of Death
	/Medic	al			mpson,	Sr.	Location of Death	April	3, 2008	8:10A.™
	Examir	er	4a. Facility Name (If not institution, give 606 South Luzer	·	4c. County of I	Death				
	Funeral Director	2	5. Social Security R1602 6. S		Year) 9.	Birthplace (State or Foreign Country) Maryland				
	pus *		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or I	ocation				10d. Inside City Limits
	Maryla fehor	ō	Md. n/a			imore Ci	F 3.7			1 XYes 2 No
	r 28e-	irect	10e. Street and Number	1	Dait	10f. Zip Code	Ly	10	g. Citizen of Wha	it Country?
	23a c	raiD	606 South Luze	erne Aven	ue	2122	4		U.S.	.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 te marked other then "neturel", or Items 23a or 28e-f show eny Injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates;	er in U.S.	. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 № No		rfy Yes or No- ican, etc.)		American Indian, White, etc. White
2-0	72 hou	ted	15. Decedent's Ec (Specify only highest gra	ucation	16a. Dec	edent's Usual Occupa e kind of work done d DO NOT use retired,	ition	1	6b. Kind of Busin	
21215-0036	vithin ne.	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)			uring most of working	,	D 11	D 1
	filed v Hygie other t	ပ္ပ	8th 17. Father's Name (First, Middle, Last)			Brakeman	18. Mother's Name (First Middle M		Road
Maryland	Jid be Jental rked c	To Be	George A.	Thompson	n			ie Fab		
lary	2 shou and h le ma		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Address (Street a	nd Number or Rural I	Route Number,	City or Town, Sta	te, Zip Code)
≥ 6	l and lealth im 27 her tr		Patricia Thomps	on (wife)	20b. Place of Disp	S. Luzer	ne Ave l			
0	ages nt of h t: If ite		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐		cemetery, cri	nosition (Name of ematory of other place Ieart of Je	9)	·	Oc. Location - Cit	
Baltimore,	permit. P Departme Importen eny Injuri		4 □Donation 5 □Other (Specify 21. Signature of Funeral Service Licen		1 2	22. Name and Addres	s of Facility acz	orowsk	i Funer	e, Maryland cal Home, PA Md. 21222
F			23a. Part1. Enter the disease or comp shock, or heart failure. List only	plications that caused th					· · · · · · · · · · · · · · · · · · ·	Approximate Interval Between
2	Physician		fmmediate Cause (Final disease or condition	Lun		ncer				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c			7.4.1.1			
	-9	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of):					
	outed nd ransit	Examiner	Sequentially list conditions, if my cause. Enter Underlying Cause (Disease or injury that initiated events	c						
50,	tificate be executed og physician and as the burial-transit	m	resulting in death) Last	Due to (or as a d	consequence of):					
68760,	physic physic the b	edical		d						
P.O. Box 6	The law requires that the death certif ite hes been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the pasl 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetaf death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
	s that pned b	by Pr	Part II. Other significant conditions co	entributing to death but r	not resulting in the	underlying cause give	n in Part I.	23e. Did toba	acco use contribu	te to the cause of death?
ğ	w require been sig should b	ted						1 ☐ Yes	s 2/2/No 3	Probably 4 Unknown
Division of Vital Records,		Completed						24a. Was an autopsy perform	ed? prior	e aulopsy findings available r to completion of cause of th? Yes 2□ No
Ĭ ĭ	ding Physician: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ont 30 DOA Othe	26. Pface of Death			
o	g Phys er this eral di	۳. ا	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y		AIL 30 DOA	4 Nursing Home		nce 6 Other (Specify)
ion	Attending Physician: r death. ector: After this certific by the funeral director.	ation	1 ♠ Natural 5 Pending 2 Accident investigation	(Month, Day Y	ear) fnjury		? ′es 2 □ No			
Divis		Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, streel, laclory, office building, etc. (Specify) 28f. Location (Street and Number or Rubbing) 28f. Location (Street and Number or Rubbing)							
	To the Hospitel or within 24 hours after to the Funeral Dir completely filled in	Medical	29a. Certifying Phy (Check only one) 2 Certifying Phy 2 Medical Exam	rsician: To the best of r iner: On the basis of ex and manner stated	ny knowledge, dea camination and/or ii d.	th occurred at the time	e, date and place, and inion, death occurred	d due to the car at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	1		29c. License		29	d. Date signed (N	fonth, Day, Year)
		1	· Ing	Kny			4315	Aı	pril 4,	2008
	6+1		30. Name and address of person who o		1.0		T 4		3.6	1 1 01004
4	Sta	e	Dr. Vincenzo G 31. Date filed (Month, Day, Year)	rippo, M. Registrar's	D. 2801 Signature	Foster	Ave. Bal	t1more	e, Mary	land 21224
*	Registra	-	APR 0 8 200	Blown	Signature	Star Barre				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** amres 02 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** BALTIMORE LAMINE RANDALLSTOWN 8. Date of Birth (Month, Day, Year) 01/02/1912 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1X M 2□F Days Hours MD 214-03-3260 96 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d Inside City Limits 1 ☐Yes 2 XNo Director MD BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21117 USA 4730 ATRIUM COURT, #230 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 No WWII If Yes, Give Year or Dates: ARMY 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: WHITE Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced ARMY Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN **PHOTOGRAPHY** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **TAMRES** KLOTZMAN CHARLES ISABELLA ం 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4730 ATRIUM COURT, #230, OWINGS MILLS, MD SYLVIA TAMRES / WIFE 20b. Place of Disposition (Name of cematers gramatery or the place)
AITZ CHAIM CONG. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/06/2008 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (included in the cause) that initiated events resulting in death) Last Examiner g physician and as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4⊠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was and autopsy performed? 1□ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 6 Other (Specify) HOSPICE Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

8

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For state amend #17 I	State o er FH G	f Maryland 3 78 4/10	/08 _C il	rtment of F	lealth and Death	Mental Hy	giene Reg. No. (0000	11001		
	Physici		Gail Annette Ume							eath Day	Year 2008	3. Time of Beath 2:00a M		
	/Medio Examin		4. Failly, Name of the first transfer of the first of the						th	4c. County of Death Prince Geor				
	Funeral Director	10M 2DF					Months Days	(Month, De Sept. 2	29,1960 Country) OH					
	Maryland f show ied at	tor	10a. State 10b. County	George		Town or Lo	cation				1	0d. Inside City Limits 1 Y Yes 2 No		
36	th with the 23a or 28a ist be notif	al Director	10e. Street and Number 12107 Ivory Fash		on Court		10f. Zip Code 20708			10g. Citizen of What Country? USA				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	Armed Fo	2⊠No ve		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2☑ No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		Race - Americ Black, White, Specify: blac	etc.		
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Maryland 2	ld be filed ental Hygi ked other ic event, t	To Be Co	17. Father's Name (<i>First, Middle, La.</i> Roosevelt Johns	_	erson			18. Mother's Na Mildred	ame (First, Middle Myles			±		
lary	2 shou and M is mar aumat	-	19a. Informant's Name/Relationship	(Type. Print)			g Address (Street					•		
	1 and Health tem 27		Egwuonwu K. Um 20a. Method of Disposition	e/ husba	20b Pi	ace of Dispo	Ivory Fa		ourt, La il 21,		MD 207 ation - City or To			
altimore,	Pages ment of ant: If if	174	1 ☐ Burial 2 ♣ Cremation 3 4 ☐ Donation 5 ☐ Other (Speed		State	st Aru	natory or other place ndal Crei	m. 20	08		on, MD			
Balt	permit. Depart Import any Inj	1 35	21. Signature of Funeral Service Lice Skels Skels		M01053		Name and Addre			Fune				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequent) of):									Interval Between		
j j	ed sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
38760,	icate be executed physician and the burial-transit	dical		d. Mi	elti pl	a M	yelow	e.						
.O. Box (The law requires that the death certificate has been signed by the attending I hage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live b	tcome pf pregnar birth 2 □ Fetal nant at time of de own	death 3□	Ectopic pregnancy Other (specify)	y		23	d. Date of delive Month	ery Day Year		
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n or	ng Phy After thi	on: To	27. Manner of Death	28a. Date		28b. Time of Injury			28d. Describe			<i>y)</i>		
Division or	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Numb City or Town, State)				
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\	To th within To th comp	Me	29b. Signature and title of certifier	(0.5)	0		29c. Licens			29d. Date signed (Month, Day, Year)				
•			30. Name and address of person wh	o completed caus	se of death (Item	23a) (Type,	D0062	2/98	,	Aprı	1 4, 20	υď		
	(V		Saul Yanovich, M	200	Pagietrar's Signat	IFO A		timore,	MD 21201					
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 8 2	008 60	Augustian o Signatura	1	W.							

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é	X 12		Registrar 1. Decedent's Name (First, Middle, La	ast)			incate or i			2. Date of [Reg. No). 		3. Time	of Death
	Physici		Alvis Vale	tice						Month Q 4	Da) 2	Year 2008		5:35 PM
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3 m	LAdiiii		Univ of Meryland	Medical Gen	ter		Balti	more							
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last	birthday)	If Under 1 Year Months Days		24 Hrs. 8	8. Date of E	Birth Day, Year)	,	9. Birthpl	lace (Sta	te or Foreign
ы	Director		231-38-0527	1 XM 2□ F	74	Yrs.	Months Days	Hours				33	Coun	VA	
	pui 🔻		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loc	eation						14	Od Incide	City Limits
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	the M	Director	10e. Street and Number		-	Dare	10f. Zip Code				10a Cit	tizon of M	Vhat Coun		
	be filed within 72 hours after death with the Marylar ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	١	4126 Westchest	er Road				216			Tog. Cit		A A	иуг	
	ns 23 mus	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. W			in? (Speci	ifv Yes or N	No-		e - Ame <i>ri</i> ca	an Indian	
·^	r iter	T.	1 ☐ Never Married 🛠 ☐ Married	Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give			Vas Decedent of H Yes, specify Cuba	an, Mexican,	Puèrto R	tican, etc.)	.	Blac	k, White, e	etc.	,
93	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give** Year or Dates:		1	☐ Yes 🎇 No	Specify:				Specify	Bla	ack	
9	72 ho natur lical	Completed	15. Decedent's E	ducation	16	6a. Deced	ent's Usual Occup	ation	of working	7	16b. K	and of Bu	siness/Ind	lustry	
2	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o O NOT use retired		or working	3					
7	led w lygier ler th		12th grade	2yrs		Br	cick Mas						vate	€	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Las	,						(First, Midd			e)		
Ĕ	should I and Men s marke umatic	မ	Willie H. Val		1	IOh Mailine	Address (Ctreat			ia Be					
Na	d 2 sl th an 7 Is r traur		Audrey Valent		I .		Address (Street) Westche								21216
	1 and Health em 27		20a. Method of Disposition	ING-MITE	20b. Place	e of Dispos	ition (Name of		Da		1		City or To		
JO L	Pages nent of I int: If its	1 8	1 X Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		ceme	etery, crem	atory or other place R i dge		1/9/0	าย			ille		
altimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. So rature of Funeral Service Lice		_ DL		Name and Address				1 1 1		1110	- / I	u
ñ	an)		Dugnes	D. Kek		43	300 Waba	ash A	ve,	Balt	imo	re,	Md	212	15
			23a. Part1. Enter the disease, or con shock, or hear vailure. List only	plications that caused to one cause on each line	he death. D	Do not ente	r the mode of dyin	g, such as o	cardiac or	respiratory	arrest,			Approxir Interval	Between
Ŋ,	Physician		Immediate Cause (Final disease or condition	_a. Pneur	20016										nd Death
186	/Medical Examiner		resulting in death)	Due to (or as a		ce of):									
	3 - 3 - 1	<u>.</u>	Sequentially list conditions,	b. Due to (or as a	20000000000	oo of):									
7	ted 1sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (unabled or injury that initiated events	Due to (or as a	consequenc	oe oi).									
	al-tra	xar	that initiated events resulting in death) Last	c Due to (or as a	consequenc	ce of):	_								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		- d									-		
9	ifficati g phy as the	edic													
Box	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pt	pregnancy							23d. Date	e of delive	ry	
ņ	deatl e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti			Ectopic pregnancy Other <i>(specify)</i>					Mor	nth	Day	Year
J.	res that the de signed by the a be detached t	hys	9 Unknown	9∐Unknown											
s,	ss thg gned se de	by F	Part II. Other significant conditions	contributing to death but	not resulting	g in the und	derlying cause give	en in Part I.		23e. Dio	tobacco i	use contr	ibute to th	e cause	of death?
g	w require been significations of the should to the state of the state	ed	Thoracic Aortic	Aneutom						10]Yes 2	□ No	3 Prob	ably 4	Onknown
Records,	law r as be 2 sh	Completed	Dementic							24a. Wa	is an	24b. V	Vere autor	osy findin	gs available
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Vita	siclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death (Check only					
7	Physi this c	ရ	1 ☐ Yes 2 No	Hospital: 1 Inpatient			3□ DOA Othe	4 🗆 1401:	sing Home	e 5□Re	sidence	6 □Othe	er (Specify)	
ב ב	dlng F	ion:	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b	b. Time of Injury	28c. Injury Work			d. Describe	e how inju	ry occurre	ed		
Sic	ttend Jeath Stor:	cat	2 Accident investigatio 3 Suicide 6 Could not b		. 41 home	form stre		Yes 2□N	-		(0)				
DIVISION OF	l or Att after de Direct I in by 1	Certification:	4 ☐ Homicide determined	28e. Place of injury building, etc.	(Specify)	idilli, stie	et, factory, office		28	f. Location City or T	own, State	n a Numb e e)	er or Hurai	i Houte N	umber,
	spltal	0	29a. Certifier 1 ☐ Certifying Pi	nysician: To the best of	my knowled	dge, death	occurred at the tin	ne, date and	d place, an	nd due to th	e cause(s	and ma	nner as st	ated	
	To the Hospital or Attending Physician: within 24 hours after death within 24 hours after death. To the Funeral Director: After this certification in the funeral director, the funeral director, the funeral director, it	edical	(Check only 2 Medical Example)	miner: On the basis of e and manner state	xamination	and/or inve	estigation, in my o	pinion, deat	h occurred	d at the time	e, date an	d place, a	and due to	the caus	e(s)
	To t To t	Ž	29b. Signature and title of contifier				29c. License	number			29d. Da	te signed	(Month, L	Day, Year	-)
}			Mily M.	0.			P 2	2206			4	5/2/0	28		
	10		30. Name and address of person who				_								
	U		A DRIAN MAUNG M 31. Date filed (Month, Day, Year)	0 P22 22			ST BAL	THORE	HO	212	101				
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DHMH 17 Rev 1/2001

1- For amend #1 Per State of Maryland / Department of Health and Mental Hygiene Phy 8878 4/08/08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 10:24 a ^M T. April Debra Deborah T. Woodfolk - Woodfolk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6732 Fox Meadow Road Baltimore Baltimore 8. Date of Birth (Month, Day, OCT 25 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 □ M 2 X F Hours 58 Maryland 1949 Director 212-56-4022 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Esaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director MD **Baltimore** Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6732 Fox Meadow Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify. 2 Specify: **Black** 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Nursing Assistant Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Douglas | Woodfolk Sonia Gibbs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Shird - Daughter 6732 Fox Meadow Road, Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 4/5/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Source Licensee H. 22. Name and Address of Facility Cremation Society of Maryland, Inc. Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Kancieatic Conce. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown HIC Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **25**No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2D No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 124 hours a 29a, Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 April 4, 2008 Trouso D3635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don Bousel, MD, 2411 Belvedere Avenue, Baltimore, MD 21215

31. Date filed (Month, Day, Year)

32. Registrar's Signature State Registrar

APR 0 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** HOWARD WOOD 3RD 1:48 AM DOCK 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENT CHESTER RIVER MANOR JOU HARMIE RD CHESTERTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09~10-1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. Hours 91 215 38 1267 PENNSTLVANIA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside Cify Limits 10b. County show items 23a or 28a-f shov Iner must be notified at 1 Yes 2 No CHESTERTOWN Director KENT 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 31930 USA 17 KENT STREET by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status r than "natural", or item the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY LAW artment of Health and Mental Hyg ortant: If Item 27 Is marked other injury or other traumatic event, is 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe HOWARD WOOD, JR. HEBE WILMER 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIS 214 MAPLE WOOD LANE, GALENA ROSIN WOOD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy gifts registry applied acce Hanover, maryland 4 Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility ANATOLAY GIFTS PSIGISTRY 7500 COUNTERED DO HADING MODIFIED 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): **Examiner** 55 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence of Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t page 2 s autopsy performed? 2**2** No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA r this Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death the Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) d title of certi se of death (Item 23a) (Type, Print) PAN PAN STES 30. Name and address of person who completed car HMOU

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Wiechert 805 A -awvence 04-04-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 509 Cedarwood Ct Bel Air If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F 02-13-1939 69 Maryland 214-36-9799 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 509 Cedarwood Ct 21014 by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates Specify Specify. White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Co. Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be George R. Wiechert Margaret Slowick Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other trau once. 509 Cedarwood Ct Bel Air, MD 21014 Anne Wiechert (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 04-08-2008 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gar. 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Crensee men D. Jewis Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 weeks Due to as a consequence of): with Brain, Liver **Physician** /Medical Examiner amiovasucula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner Metastoke Lung To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) TYAS 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performer?? 1 □ Yes 2 DNo 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 X Natural 2 Accident 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

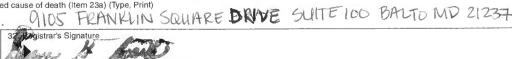
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

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State Registrar

Aygun ENOIZ Year) APR 0 8

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D



29c. License number

29d. Date signed (Month, Day, Year)

04.04.08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 230 2008 am Candie B. Wilson 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Jaky land General Baltimore n/a If Under 1 Year | If Under 24 Hrs. 8. Social Security Number In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 □ F 243-36-5229 87 10/20/1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ¶Yes 2 No n/a Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21216 USA 3124 Presstman Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African-American 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) City Of Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Highway dept. 4th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ceasar Wilson Lizzie Hanna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5806 Highgate Drive, Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Manorial Park 4-12-08 Ar Juliet Saunders/Daughter Location - City or Town, State 20a. Method of Disposition N Burial 2 □ Cremation 3 Removal from State Arbutus, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fureral Service Licen 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2000 25. Was case examiner

1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be 10

Funeral

Director

Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

21215-0036

Maryland

Baltimore,

Examiner Physician/Medical

burial-trar the attending physician the for use been signed by to should be detach director, page 2 should this certificate has completely filled in by the fur eral within 24 hours after death.

To the Funeral Director: A er

þ

Completed

Be

Certification: To

Medical

4 Homicide

29a. Certifier

The law requires that the death certificate be executed

or Attending

Fo the Hospital

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	
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25. Was case referred to medical	26. Place of D	leath (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other
27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred

M

1 Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

agra (

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐Other (Specify)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (trem 23a) (Type, Print)

31. Date filed (Month, Day, Yelar)

State Registrar

5

APR 08 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🖺 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 ear APRIL **Physician** 4 12:28P [™] ZELDIN SONYA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5 RUSSERN COURT, APT. BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 212-23-9867 84 01/04/1924 BELARUS Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if than "natural", or items 23a or 28a-f sho 1 X Yes 2 □ No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 5 RUSSERN COURT, APT. 1-B 21215 USA by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☒No Specify WHITE If Yes, Give Year or Dates: Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other tha any injury or other traumatic event, It. A. Once. DENTIST DENTISTRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEYVIK KAGAN ROZA UNOBTAINABLE ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2729 VALLEY PARK DRIVE, BALTIMORE, MD 21209 MARGARITA PODYACHEV/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 04/06/2008 REISTERSTOWN, MD 5 Other (Specify) 4 Donation of uneral Service Livense 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of and Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year for Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Arleindon 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an nis certificate has director, page 2: 1 ☐Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၀ this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Court nd: Baltimen. 31. Date filed (Month, Day, Year) Registrar's Signature State APR 08 Registrar

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 or Attending

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: / Hospital

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 25 MAR 2008

NOW

MOCDEMBRO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

TIPAPORN



ORIGINAL

29c. License number

D. 17656

\$SSU,

29d. Date signed (Month, Day, Year)

3/20/08

CNASE

CHIZM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Carolyn V. Alexander 21 2008 March 1:58A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 12214 Old Fort Road Fort Washington Prince George 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct.17, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 K F Director 579-28-8151 1926 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits works "natural", or items 23a or 28a-f shov dical Exa⊞lner must be notlfied at 1 ☐ Yes 2 No Maryland Prince George's Director Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12214 Old Fort Road 20744 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Nidowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry ould be filed within 12 d Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Ernest Joseph Vargo Mildred Habblett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,1 and 2 sh ,f Health ar / item 27 is Kathy Hayes/Daughter Edens Lane Lugoff, South Carolina 29078 25 permit. Pages 1 a
Department of He
Important: If item
any injury or oth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation S☐ Other (Specify) Maryland Veterans Cem. 3/25/2008 | Cheltenham, Maryland uneral Service Lio 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home alle 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause by each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHROKIC OBSTRUCTIVE PULMONARY DISEASE **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2ĬNo Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform cate 1□ Yes 21 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\forall \text{ Residence} 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No P 1 Inpatient 2 ER/Outpatient 3 🗆 D0A 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No I Director: 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Medical 10 State Registrar

31. Date filed (Month, Day, Year) MAR 2 4 2008

29b. Signature and title of certifier

(Check only one)

Heihn Nguyen, M.D. 6104 Old Branch Ave., Temple Hills, MD 20748 32. Registrar's Signature

MI

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0057518

29d. Date signed (Month, Day, Year)

March 21, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10a-c ef per inf 9879 5-6-08 yt.
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2008 11:25 03 Margerie P. Abe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Allegany** Moran Manor Health Care Center Westernport If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2/7/F Yrs. Director 07/29/1916 Cumberland, MD 233-04-6737 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show other traumatic evant, the Madical Examinar rount be notified at 1 □Yes 2 □No **Mineral Piedmont** W VA Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiene important; if Item 27 is marked other than "natural", or Items 23a or 2. Any Injury or other traumatic event, the Medical Examinar ance. 26750 36 Pearl St. U.S.A. 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 X If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be E.G. Burkhart Bessie R. McCray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 65 Slanesville, WV 25444 Shirley Jean Harden/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Durial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Abe Family Cemetery 03/26/2008 Wiley Ford, WV 22. Name and Address of Facility Smith Funeral Home 21. Signature of Funeral Service Licensee 85 S. Main Street Keyser, WV 26726 23a Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Endstage Pnysician Coronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ milletus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ known Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 212 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 5 Pending investigation → ONatural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D21244 3/31/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, M.D. 4 Broadway Frostburg, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar APR 0 8 2008

DHMH 17 Rev 1/2001

ORIGINAL

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONT

2008

32. Registra Signature

D 0022236

FBIS (M) - JOHNS HOVELDS HUSPIAL, BALTIMORE, M) 21897

March 25,2008

600 N. WORFEST.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Walter G. Boyd, Ir. 0115 AM 23 , 2008 /Medical March 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death De Harre Home Grace Marford Vursing | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | July 23, 10 9. Birthplace (State or Foreign Country) MaryLand Funeral 1 XM 2 □ F 1918 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 MYes 2 □ No Directo Maryland | Harkord Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 106 Deaver Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter - Supervisor Civil Service Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter G. Boyd Lillie Benjamin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audreu E. Boud (Spouse) 106 Deaver Street, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Harford Mem. Gardens 3/28/2008 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service Licenses 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or control cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hrs disease or condition resulting in death) /Medical Due to (of a a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ W 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 🗀 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 ☐ 1 € 0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

Records, P.O. Box 68760. Division or Vital

altimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 2

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kamnoly

Miliam , The

D 32609

29d. Date signed (Month, Day, Year)

1106 Revalution & Havrede Gran

MAR 2 8 2008 31. Date filed (Month, 32. Registrar's Signature

w requires that the death certificate be executed	Ph /: Ex	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan
	ıy: Mı ca	Department of Health and Mental Hygiene.
been signed by the attending physician and	sic ed m	Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
should be detached for use as the burial-transit	eia ic in	any Injury or other traumatic event, the Medical Examiner must be notified at

		1 - State Registrar	Ce	ertificate of L	Death		Reg. No. 2	008	11336
Physic	an	Decedent's Name (First, Middle, Last)				2. Date of De Month		008 ear	3. Time of Death
/Medi	cal	Barbara Smith Broomfield 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	March		y of Death	11:15 AM
Exami	ner	Anne Arundel Medical Center		Annapolis				Arund	lel
Funeral Director		5. Social Security Number 6. Sex $1 \square M$ 2 TMF 7. Age (In yrs. 135-28-2695 Usual Residence of Decedent	last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June 10	th ay, Year) 0, 1932	Cour	lace (State or Foreign try) Jersey
yland now at	1		y, Town or	Location				1	0d. Inside City Limits
e Mar 3a-f st tiffed	Director	Maryland Anne Arundel Ar	napol	lis					1 □Yes 2□No
with the		10e. Street and Number		10f. Zip Code			10g. Citizen of		,
leath v	Funeral	1038 01d Bay Ridge Road 11. Marital Status 12. Was Decedent Ever in U.	S. 13	21403 B. Was Decedent of His If Yes, specity Cuba	spanic Origin? (Sr	ecify Yes or No	United	ce - Americ	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes □ Yes TWO Yes A TWO Yes A TWO Yes A TWO Yes A TWO Yes A TWO Yes A TWO Yes A TWO YES A		If Yes, specity Cuba	n', Mexican', Puerto Specity:	Rican, etc.)		nck, White, fy: Whi	
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within ene. than he Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ine	Homemaker)		Owi	n Home	<u>.</u>
e filed al Hygi other rent,	Be Co	17. Father's Name (First, Middle, Last)		1101110111011	18. Mother's Nam	ne (First, Middle			
ould be Menta arked atlc ev	To E	Leon A. Smith			Dorthea	Jahn			
and 2 sho ealth and 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) James A. Broomfield / Son		iling Address <i>(Street a</i> 3 Old Bay I					,
ges 1 grof He		20a. Method of Disposition 20b. F 1 1 1 1 1 1 1 1 1 2 1 2 2 2 2 2 2 2 2 2	Place of Dis cemetery, co	position (Name of rematory or other place	e)	Date	20c. Location	- City or To	own, State
t. Pag rtment rtant:		4 □ Donation 5 □ Other (Specify) Ba		ce Nat'l Ce					
permi Depa Impo any It		21. Signature of Funeral Service Licensee		147 Duke of					1 Home,Inc MD 21401
		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.					ırrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	EM	IA SEF	515			2	LOAYS
Examiner		Immediate Cause (Final disease or condition resulting in death) a. BACTER Due to (or as a conseq Sequentially list conditions,	uence or):	CINAMI	a LUNG	5		2	LYEARS
₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.1				
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rificate be executed ng physician and as the burial-transit		d.	d erioe oi).						
a G	Medical	IF FEMALE:							
The law requires that the death ce the law requires that the death ce the has been signed by the attendings 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months 1 □ Yes 2 □ Hotel 1 □ Yes 2 □ Hotel 1 □ Yes 2 □ Hotel 1 □ Yes 2 □ Hotel 1 □ Yes 2 □ Hotel 1 □ Yes 2 □ Hotel 1 □ Yes 2 □ Hotel 1 □ Yes 2 □ Hotel 1 □ Yes 3 □ Unknown	al death 3	B□Ectopic pregnancy Double (specify)				ate of delive lonth	ery Day Year
s that i		Part II. Other significant conditions contributing to death but not res	ulting in the	underlying cause give	en in Part I.	23e. Did	tobacco use coi	ntribute to t	ne cause of death?
w requires to been signer should be of	ed b	UPPER GASTRO, NTEST,	NAC	BUZED		10	es 2□No	3 ☐ Prob	oably 4 □Unknown
law ri las be	Completed by	GASTRIC VICERS				24a. Was	an 24b	. Were auto	psy findings available mpletion of cause of
r: The icate h			OCA	LUNG	5	perf 1□ Yes	ormed?	death?	2□ No
Attending Physician: Tr r death. ector: After this certificate by the funeral director, pag	Be C	25. Was case referred to medical examiner? 1 — Yes 21 100 Hospital: 1 1 1 Impattent 2	I SP/Outpat	ient 3 DOA Othe	er:				
g Physier this	n: To	27. Manner of Death 28a. Date of Injury	28b. Time	of 28c. Injury	4 Li Nursing n		idence 6 🗆0 how injury occu		у)
endin sath. or: Aft he fur	atio	2 Accident investigation		M 1□'	Yes 2 □ No				
i i i i i i i i i i i i i i i i i i i	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Specif	ome, farm, fy)	street, factory, office		28f. Location City or To	(Street and Num wn, State)	ber or Run	al Route Number,
24 hg 24 hg Fun etely	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my known one and manner stated.							
To the within To the comple	Ž	29b. Signature and title of certifier		29c. License		72	29d. Date sign		
and	J	MUCH MD	nfr		3832	0	03-	19-	2008
1/2		30. Name and address of person who completed cause of death (Iter	NG	AN UNDGI	ME.DI	CAZ C	ENT 5	1	
	ate	31. Date filed (Month, Day, Year) MAR 2 4 2008 32. Redistrar's Signal	ature	1		,	- / 4 (2)		
Regist		MITH N & LOUD	D.	god			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Month Year 9:05 A^M LAURA ANN BERMEL 26, March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 107 Hickory Lane Elkton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1□M 2√2F 208-62-9649 Director 36 12/3/1971 Wynnewood, PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location a or 28a-f show t be notified at 10d. Inside City Limits Director 1 □ Yes 2√No Elkton MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r Items 23a o 107 Hickory Lane 19709 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 10, White 1 ☐ Yes 2 No þ Specify: 21215-003 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paralegal Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be item 27 is marked other traumatic ev P Paul J. Small Theresa A. Callaghan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21921 Steve Bermel 107 Hickory Lane, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 Removal from State Old Drawyer's Cem. 3/31/2008 Odessa, DE 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME LLC 23a. Part1. Enter the disease, it a implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate interval Between onset and Death. DE 19709 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physician and as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No.
9 ☐ Unknown 23d. Date of delivery 3 □Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Vo certificate has autopsy perform funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) After this Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending (Month, Day Year) 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Bria 32. Registrar State 2008 Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 3 JAMES LEROY BROOME /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Saint Mary's Hospital Saint Marys Leonardtown
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/3/1929 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days **X** 2 □ F Hours Min. 79 NC Director 240-36-1954 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County fshow ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 🎖 🗖 No MD Saint Marys Charlotte Hall 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: 1946 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes ⅩXNo 3altimore, Maryland 21215-0036 Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Broome Ella Boyce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Broome/ Daughter 5210 Kenmont Rd., Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot Nation 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'1CEM 4/3/2008 Arlington, Virginia 22. Name and Address of Facility Greene Funeral Home 21. Signature of Funeral Service Licensee nelson & Green 814 Franklin St., Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Dav 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ Ho Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၀ 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation Injury 1 □ Yes 2 □ No spital or Attendlinours after death. Ineral Director: A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year)

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State 31. Date filed (Month, Day, Year)

Registrar MAR 2 4 2008

Manoj



30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

37767 Market Drive, Charlotte Hall, MD 20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Kelly Sue Bradford 1:13 a 03/24/2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City, Town, or Location of Death Examiner 16306 St. Thomas Church Road Upper Marlboro Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 🗙 F 577-82-3759 31 03/14/1977 TY Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes Ž No is 1 and 2 should be filed within 72 hours after death with the Man if Health and Mental Hyginen.

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In Health and Mental Hyginen.

In Health and Saa or 28a-f sh in the Argential or 1 in the Medical Examiner must be notified other traumatic event, the Medical Examiner must be notified. Director MD Prince Georges Upper Marlboro 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20772 U.S.A. 16306 St. Thomas Church Road Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Geriatric Social Care State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Randal Melvin Bradford Jacqeline Elaine Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any injury or other traun once. Randal Melvin Bradford/Father 16306 St. Thomas Church Rd., Upper Marlboro MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signature → Fineral Service Ligenge Lee Crematory 03/27/2008 Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Md Blvd., Owings MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hodgkins Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Enter Inderlying. Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🔲 Yes 2

No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Was ... autopsy performed? Ves 2∰No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of oertifier

State Registrar wi

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrans Signature

1266665

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 2008 \mathbf{P}^{M} March 21, James Buchanan Busey, 3:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b, City, Town, or Location of Death 660 Miriam Lane Lusby Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) April 2, 1962 Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. **1X** M 2 □ F 545-37-0775 45 Director California Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show r 28a-f show r notified at 1 ☐ Yes 2 XNo Director Maryland | Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 660 Miriam Lane 20657 United States Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after anns of Health and Mental Hygiene. anns of Health and State and the than "natural", or ite anns to the traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2√No <u>م</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Test Flight Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ James Buchanan Busey, IV Jean Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charlotte M. Busey / Wife 660 Miriam Lane, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot Metropolitan Crematory 3/24/2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one "ause on "ach line." Approximate Interval Between Onset and Death Immediate Cause (Final Cancer 1et asta Physician 0 disease or condition resulting in death) /Medical Due to (or as a conse uence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Month Year Day 5 Other (specify) P.O. I ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown s teen signed by 2 should be detact Part II. Other ignificant conditions contributed to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 25 Seale 101 Melanora 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an rector, page 2 autopsy The performed Division or Vital 1 Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pl 24 hours after death. e Funeral Director: After t 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0054263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOOKOUT RO. LEONARATOWN MD 20650 32. Registra's Signature 31. Date filed (Month, Day, State MAR 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Terry Robin Butler 2008 March 4:32 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Director 217-60-9546 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or Items be notified at ury or other traumaft event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TNo Funeral Director MD Calvert North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3557 6th Street 20714 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕅 No ģ Specify white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ John Watson Butler Alice Lorraine Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen L. Butler, spouse 3557 6th Street, North Beach, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or So. Memorial Gardens: 03-28-2008 Dunkirk, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** nd Stage Due to (or as a consequence of): Obstructive Airway Diverse hronic /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical as 1F 23t certificate has been signed by the a rector, page 2 should be detached Par þ Be Completed 25. 27

physician and the burial-trans

Baltimore, Maryland 21215-0036

Medical Certification: To

FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
_	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Possible Pleural	ung cancer	24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	26. Place of Death (C Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 ☐ Nursing Home	Check only one) 5 ☐ Residence 6 ☐ Other (Specify)
Manner of Death 1 Natural 5 Pending investigat	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Injury at Work? 1 Yes 2 No	d. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determine		. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

KW

n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu

completely

(Check only one)

29b. Signature and title of certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851-Deale Churchter

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 50653 3-24-2008

C. SURANA GYAN Deale

Registrar

31. Date filed (Month, Day, Year) 32. Registre s Signature MAR 2 5 2008

Surano

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Elmer Edward BLACKBURN 2008 /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 X M 2 □ F Maryland 213-30-1950 76 July 26, 1931 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 AYes 2 No Hagerstown Washington Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 USA 11 W. Baltimore Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: UNKNOWN 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify δ 3 XWidowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Monce. road worker county 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Blackburn Agnes Winggington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Church - daughter 828 N. Ridgewood Ave., Ormond Beach, F1. 32174 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Hagerstown Crematory 3/29/08 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary **Physician** /Medical Due to (or as a consequence of): **Examiner** JPOX10 Sequentially list conditions, as a consequence of): rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Diskask Chrunic Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician una Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 (No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mann eath 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

11-31 State

Registrar

RSHED FARID 31. Date filed (Month, Day, Year)

MAR 2 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

29b. Signature and title of certifier

29c. License number

1126

106039

Opal

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ŀ	1 - For State Registrar	State of Ma	aryland		artment of I	Health and I Death	Mental Hy	gien Reg. N		113	343
	Division		Decedent's Name (First, Middle,	Last)					2. Date of De		ay Year	3. Time of	Death
-	Physici /Medi Examir	cal	Bessie May Cleme				4b. City, Town,	or Location of Death	March :	24,	2008 c. County of Deatl	8:15	P ^M
	2.40		Montgomery Gener	al Hospital			Olney			M	ontgomer	У	
	Funeral Director					ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da	rth ay, Yea	7) 9. Birtl	nplace (State or untry) Sinia	r Foreign
	P .		Usual Residence of Decedent							,			
	Marylar I ehow	tor	10a. State 10b. County 10a Maryland Montgom	erv	01ne	, Town or Lo	ocation					10d. Inside Cit 1 ☐ Yes	-
	h the	Irec	10e. Street and Number	CLY	OTHE	7	10f. Zip Code			10g. C	itizen of What Co	untry?	
	th wit	aiD	3805 Holly View	Street			20832			USA			
	eep E	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	S. 13.		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No	0-	14. Race - Ame Black, White		
21215-0036	n 72 hours after deeth with the Maryland "natural", or iteme 23s or 28s-f show edical Examinat must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced		No		1 ☐ Yes 2 🗓 No		5 man, 515.7		Specify: Whi		
2-0	72 ho	ted	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occu	pation during most of wor	rkina	16b.	Kind of Business/	ndustry	
2	- 30	npie	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use retire	ed)	King	1	tgomery	_	
	ihould be filed within Id Mental Hygiene. marked other than matic event, the Mi	S	12			Cafet	eria Wor	T			lic Scho	ols	
P	be fit d off	Be	17. Father's Name (First, Middle, La	st)				18. Mother's Nar	ne (First, Middle	, Maide	en Sumame)		
3	Men Merke Patic	2	Guy Leith Payne			T		Ella Doi					
Maryland	12 sh h and 7 ie n traun		19a. Informant's Name/Relationship					t and Number or Ru					017/
e,	1 and Healt em 2		Barbara Dunn, da	uchter	20b. Pl		Herman Osition (Name of	Myers Roa	ad, Hage Date		own, Mar Location - City or		21742
Baltimore,	if it		1 X Burial 2 Cremation 3 Removal from State 4 Contains 5 Other (Specify) Parklawn Memorial Park 3/29/2008 Rocky:										
Ē	rtant				Parl								
Ba	permit. Pages 1 and 2 should be lifed within Department of Health and Mental Hygiere. Important: if item 27 ie marked other than any injury or other traumatic event, ILE MODG.		21. Signature of Fu eral Service Lie	Deren		2	6401 Rid	ess of Facility Mo ge Road,	Damascu	s,		20872	
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.O. Box 6	The law requires that the death certificate be executed ste hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1 □ Yes 2 ❷ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pregnand Other (specify)	ey			23d. Date of deli Month		'ear
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Division of Vital	or Attence after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Inju- building, etc	ury - At hor c. (Specify	me, farm, st	reet, factory, office		28f. Location (City or To	(Street a	and Number or Ru te)	ral Route Numb	ber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 X Certifying (Check only one) 2 Medical Ex	Physician: To the best of eminer: On the basis of and manner sta	fexaminat	vledge, deat on and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the arred at the time,	cause date a	(s) and manner as nd place, and due	stated. to the cause(s))
	To th To th comp	Me.	29b. Signature and title of certifier				29c. Licen	se number		29d. C	Date signed (Monti	n, Day, Year)	
			> Yoka	1			D003	5045	1	Marc	ch 25, 20	800	
	10		30. Name and address of person with	o completed cause of d	eath (Item	23а) (Туре,			1-				
	10		Philip G. Henjum 31. Date filed (Month, Day, Year)	, MD, 18109	Pri	nce Ph	ilip Dri	ve, #200	Olney,	Ма	ryland	20832	
	Sta	rte	BAAD	2 6 2000 N	- Orginal	Lo	A. M.						

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Coll James Murray 2008 Terch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cambridge Dorchester General Vorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 24, 5. Social Security Number 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** Year) 1⊠M 2□F 1937 Maryland Director 214-34-7811 70 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show Examiner must be notified at Cambridge TyF Yes 2 □ No Dorchester MD Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 21613 1106 Glasgow Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married "natural", or white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other transmath. Elementary/Secondary (0-12) College (1-4or 5+) land surveying surveyor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathleen Henry Thomas L. Coll ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 533, Cambridge, MD 21613 wife Ann Coll 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury, MD Salisbury Crematory 3/24/08 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility 21. Signature Fineral Service bicensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) bronchod/veo/2 **Physician** /Medical Due to (or as a consequence of): Examiner neumonia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 4□Pregnant at time of death 5 ☐ Other (specify) the a 9∏Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 2 No 1□ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending Injury 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1100 599 73

State Registrar

DHMH 17 Rev 1/2001

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30. Name in address of person who completed cause of death (Item 33) top Police Street
Patricia Johnson 100 Cambrida . N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** CHARLES DONALD CLARK MARCH 19 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **OUEEN ANNE'S** CHESTER 1854 HARBOR DRIVE Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Social Security Number Hours **Funeral** Year) Days Min. 1 M 2 □ F Months Director 83 SEPTEMBER 27, 1924 MARYLAND 217-16-6234 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2 No Director MARYLAND QUEEN ANNE'S CHESTER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with "natural", or Items 23a 1854 HARBOR DRIVE UNITED STATES 21619 Examiner must Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: WHITE If Yes, Give Year or Dates:1942-1946 by 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 POLICE OFFICER LAW ENFORCEMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN EOUIS CLARK EDITH E. MAYOR ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA D. CLARK/DAUGHTER 328 BIGLEY AVENUE, BALTIMORE, MARYLAND 21227 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition MARCH 25 HURLOCK MARYLAND 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HURLOCK, MARYLAND 4 Donation 5 Other (Specify) 2008 VETERANS CEMETERY LEuneral Pervice License 21. Signatur FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. shock, or h Immediate Cause Due to (or a a consequence of): hours Physician disease or condition resulting in death) /Medical Examiner 4 ear canc unq Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examiner certificate be executed as the burial-transit and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Month Day Year in the past 12 months? 5 Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cancel been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 212-No has certificate 2 No 1 Yes 1□ Yes Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 1 ☐ Yes 2 1 Inpatient 2 ☐ ER/Outpatient this funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one)

Tooler, 3900

State Registrar

29b. Signature and title of certifier

deret 31. Date filed (Month, Day, Year)

Marg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Malaro

32. Registrar's Signature

DHMH 17 Rev 1/2001

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NID

M.D.

29c. License number

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Sallitt Drive Stevensnile, MD

29d. Date signed (Month, Day, Year)

		For State	State of I	Marylan		partment of He		d Mental Hy	4,00	008	11346
		Registrar 1. Decedent's Name (First, Middle, La	ast)			erincate or L	- Call	2. Date of De	Reg. No.		3. Time of Death
Physici	an			CILIA				Month MARCH	Day 27	2008	6:45 a ^M
/Medie		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of De			County of Dea	
Examir	ier	Chester River							IV.	nt	
F				Age (In yrs. I	ast birthda	Cheste:	If Under 24 H		th	ent 9. Bir	thplace (State or Foreign
Funeral Director		180-24-6367	1 □ M 2 🖾 F	77	Yrs.	Months Davs	Hours Mi				o <i>untry)</i> ennsylvania
		Usual Residence of Decedent						Duly 2		J J U I U	
show ad et		10a. State 10b. County		10c. City	, Town or	Location					10d. Inside City Limits
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r 28g	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What C	ountry?
h with	<u>e</u>	14115 Park Rd	•			21645			U.S	.A.	
deat	Funeral	11. Marital Status	12. Was Decede		S. 1	Was Decedent of His If Yes, specify Cubar	spanic Origin?	(Specify Yes or No	o- 1	4. Race - Am Black, Whi	
or its	F	1 ☐ Never Married 2 ☐ Married	1 Tes 2			1 ☐ Yes 212 No	Specify:	orto moun, oto.,			hite
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ygier tr		12	43		56	cretary	10 Mothodo A	Name (First, Middle	1	itract	ors
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinational be maitilied at once.		Anthony J. Ce	ecilia (husba	nd)	14115 Pa:	rk Rd.	<u>Kenned</u>	yvil	le, M	ID. 21645
Pages 1 nent of 1- nnt: if its		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3	☐Removal from Sta	ate	emetery, c	rematory or other place					
Fant:		`4 □Donation 5 □ Other (Spec		Sh	rews	bury Cem		1/08	Ken	inedyv	ille, MD
Departiment Depart		21. Signature of Funeral Service Lice	3/		G	22. Name and Addres	s of Facility neral	Home of	Ste	phen	L. Schaech
1 005 e o		(90)		M0051	0 1	18 West	Cross	St. Gal	ena,	MD	L. Schaech
		23a. Partt. Enter the disease, or cor shock, or heart failure. List ont	nplications that cau y one cause on eac	ised the death Ine.	n. Do not e	enter the mode of dying	g, such as card	fiac or respiratory a	arrest,		Approximate Interval Between Inset and Death
Physician		Immediate Cause (Final disease or condition	a (are	ourd	ras	enlar	acci	dent			4 days
/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):	-					
Cxammer	_	Sequentially list conditions,	b								
sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence or):						
ate be executed hysician and the burial-transit	cam	that initiated events resulting in death) Last	C. Due to (or	35 3 CODSAG	rence of).						
be ex cian a											
cate be executed obysician and the burial-transit	dical		d								
ling p e as	Me	IF FEMALE:	OD- Hugo outon								
ath o ttenc	Physician/Me	23b. Was decedent pregnant in the past 12 months?		h 2∐Feta	death	3 Ectopic pregnancy			2	23d. Date of de Month	Day Year
the a	slc	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregnar 9☐Unknow	nt at time of d n	eatn	5 Other (specify)					
hat the deby detac		Part II. Other significant conditions	contributing to dea	th but not resi	ulting in the	underlying cause give	en in Part I.	23e. Did	tobacco u	se contribute t	to the cause of death?
res t signe l be c	þ	11 Cd Cd	h		ang u.v.	o undonying oddoo give		1 🗆	Yes 2	2 /No 3 □ F	Probably 4 Unknown
requir een s	ted	Lung ama						-			
law law lasb	npfe							24a. Wa:		prior to death?	utopsy findings available completion of cause of
The The Sate I	Completed							1 ☐ Yes	2 No	1 ☐ Ye	s 2 No
cian: ertific	Be	25. Was case referred to medical examiner?	Harrison V.			To::-		Death (Check only	one)		
hysii his c	P	1 □ Yes 2 No			ER/Outpat		4 🗆 14013111	g Home 5 ☐ Res			ecify)
nding Pl th. : Atter the	on:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time Injur	y Work		28d. Describe	how injury	y occurred	
eath.	catl	Accident investigati	ha				Yes 2□No		(0)		
r Attainter dea	Certification:	3 ☐ Suicide 6 ☐ Could not determine	289. Place 0	f Injury - At ho g, etc. <i>(Specif</i>	ome, farm, v)	street, factory, office			(Street and own, State)		Rural Route Number,
rs af c											
To the Hospital or Attanding Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Example 1	Physician: To the bas aminer: On the bas and manne	is of examina	wledge, de tion and/or	eath occurred at the tim r investigation, in my of	e, date and pla pinion, death o	ace, and due to the ccurred at the time	cause(s) , date and	and manner a place, and du	as stated. ue to the cause(s)
To the within To the Comp	Me	29b. Signature and title of certifier				29c. License	number	0	29d. Date	e signed (Mor	nth, Day, Year)
,		10001				2/6	, 78°	Ö	3-	28	~ 08
of agree		30. Name and address of person wh			1 23a) (Typ	pe, Print)					
M2.		Wayne D. Ben	jamin, N	1.D.	6602	2 Church	Hill F	Rd. Ches	stert	town,	MD. 21620
	ate	31. Date filed (Month, Day, Year)		gistrar's Signa							
Regist	rar	MAR 2	8 2008	The gree	1	Spele					
DHMH 17 Rev 1/2	2001										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CORRAL /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMELY 5 WWBAN 6511504 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1X M 2□ F 215-67-6871 Director 71 Jan. Philippines Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show Director 1 ☐ Yes 2 X No be notified Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 20902 2811 Kingswell Drive Philippines items 23a "natural", or items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21€ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2√ No Specify. Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the M Supervisor Heavy Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sergio Benito Corteza Rosenda Corral 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Vida C. Benabese/Daughter 2811 Kingswell Drive, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 25 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Metropolitan Crematory Alexandria, Virginia 4 □ Donati 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Sign/tur 500 University Blvd. W, Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CARDIOGENIC SHOCK **Physician** tous resulting in death) /Medical Due to (or as a consequence of): Examiner FIBELLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed ENTRICULAR FIBRILLATION attending physician and for use as the burial-trans Due to (or as a consequence of): certificate be VARCULAR Physician/Medical ERBALECTIC CORONARY IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9□Unknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 🖍 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760 P.O. I Records, or Vital or Attending Physician; Division To the Hospital

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director; After completely filled in by the funer.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

l 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signat d title of certifier

29a. Certifier

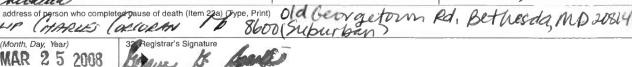
29c. License number DE038159 - MD 29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year)

25





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9878 4-17-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 20,2008 9:15p M March Corbett Claudia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 3501 Forest Edge Drive Apt.2A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 5 Month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month | 5 month . Social Security N**5999** 093-24-590 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💆 F 87 Director Ukraine Usual Residence of Decedent 10c. City, Town or Location Silver Spring 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at MD Montgomery 1 ☐ Yes 2 TNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or USA 20906 3501 Forest Edge Drive Apt.2A "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2☐**X**No Yes, Give 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Nurse 18. Mother's Name (First, Middle, Maiden Surname)
Antonia unknown 17. Father's Name (First, Middle, Last) Be Herasym Melnyk ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20905 19a. Informant's Name/Relationship (Type. Print) Friend-Rev. Vladimir Steliac/P.O.A. 15100 New Hampshire Ave. Silver Spring, Md 20b. Place of Disposition (Name of Steme An Ormalos or other place)
Ukrainian Orth.Cem South Bound Brook, New Jersey 20a. Method of Disposition 3/25/2008 permit. Pages Department of Important: If it any Injury or o 1⊠ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 □ Donation 5 □ Other (Specify PHYDEP AD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21. Signature uneral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular accident disease or condition resulting in death) 8 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the bunal-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown end stage chronic renal failure Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No s certificate has the lirector, page 2 s autopsy performed? 1 | Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2|X No 1 Tes 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) March 24,2008 29b. Signature and title of certifier 29c. License number mauni mo D24543 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Rossi MD 3305 N.Leisure World Blvd.Silver Spring, Md 20906

State

Registrar

31. Date filed (Month, Day, Year)

MAR 25

2008

32 Segistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month Physician Madeline A. Collins Anna Madaline Collins March 21, 10:45a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign Country) 3114 Gracefield Road, WC 306 Silver Spring
If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) July 17, 19 7. Age (In yrs. last birthday) Funeral Days 1 ☐ M 2 🔀 F Yrs. Michigan 272-46-1667 94 1913 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes XXNo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with "natural", or items 23a 3114 Gracefield Road, WC 306 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify þ Specify. 3 X Widowed 4 □ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi ment of Health and Mental Hygiene. ant: If item 27 is marked other than Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel H. Neumaier M. Laura Foley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 40 West Chesapeake Avenue, Suite 200, Towson, MD 19a. Informant's Name/Relationship (Type. Print) Maxwell R. Collins, II/Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan Crematory Important: If it any Injury or o March 22 Alexandria, Virginia 5 ☐ Other (Specify) 4 Donation 2008 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd. W., Silver Spr 21. Sign uure Spring, MD 20901 23a. P4nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Congestive Heart Failure /Medical resulting in death) Due to (or as a consequence of): Examiner Mitral Valvular Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 5 ☐ Other (specify) the detached 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending To the Hospitar or recognition 24 hours after death.

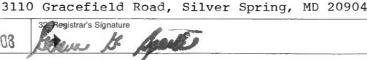
To the Funeral Director: Aff 1 Natural 5 ☐ Pending Injury M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🎦 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D03450 March 21, 2008 rei 30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

MAR 2 5 2008

Roy Fried, MD



Baltimore, Maryland 21215-0036

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Records,

Division or Vital

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Items 25,27,28a-1 per me, 2880,06/04/08dhb

Reg. No. 2 1 118 1. Decedent's Name (First, Middle, Last) Hazel Dorothy Courm 2. Date of Death Day **Physician** 2:15 A^M HAZEL DOROTHY CORUM 2008 08, March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Woodside Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours May 23, 1920 Virginia Director 577-20-1752 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No DC Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20011 4900 3rd Street, NW by Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 XWidowed 4 ☐ Divorced **Black** "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical Elementary/Secondary (0-12) College (1-4or 5+) other than DC Public Health the yrs. Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be t Clarence Lee Nannie Wells ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:3 Department of Health at Important: If item 27 is any injury or other trau once. 513 47th Street, NE Washington, DC 20019 Michelle Monroe/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland National Cem 03-13-2008 | Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4217 9th Street, NW Washington, DC 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronau **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events CATION APPROVED BY MEDICAL EXAMINER Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 XNo 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) Ö 9 ☐ Unknown Δ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division or Vital Records, eihners 1 Tes 2 No 3 Probably 4 Munknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an nas autopsy performed? certificate 2 💢 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XIYes 2XINo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XAccident 02/01/2008 Unknown M or Attending 5 ☐ Pending investigation Subject fell. 1 ☐ Yes 2 No 24 hours a er death. the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1330 Massachusetts Ave., NW, Washington, D.C. 3 Suicide determined filled in by 4 ☐ Homicide Assisted Living Facility Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated within 2 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARZANA AJMA Date filed (Month, Day, Ye MAR 2 5 2008 32. Registrar's Sig State Registrar

			For State Registrar	State of Mary	-	artment of F rtificate of			ne.2008	11351
	Physici	an	Decedent's Name (First, Middle, La Harold Coleman	st)				2. Date of Death Month	1 ⁹ , 2008 ^{ar}	3. Time of Death 4:25 AM
	/Medio Examir		4a. Facility Name (If not institution, give Fox Chase Rehab.			4b. City, Town, C	r Location of Death Spring		4c. County of Death	
	Funeral Director		377	6ex 7. Age (In 84	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes)	ear) Cou	place (State or Foreign ntry) ington, DC
	Maryland a-f show ified at	stor	Usual Residence of Decedent 10a. State 10b. County Montgor		City, Town or Lo			*		10d. Inside City Limits 1 X Yes 2 No
	th with the 23a or 28 ust be not	al Dire	10e. Street and Number 2015 East West H	ighway		10f. Zip Code 20910		"	Citizen of What Cou Inited Stat	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 █ Divorced	12. Was Decedent Ever Agned Forces? 1 Pyes 2 No If Yes, Give Year or Dates:	WW III	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Black	etc.
21215-0036	within 72 ho iene. r than "natu the Medical	Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire cary Offi	during most of wor d)	king	b. Kind of Business/Ir	-
Maryland 2	ruld be filed Mental Hyg arked other atic event, 1	To Be C	17. Father's Name (First, Middle, Last John Coleman)				ne (First, Middle, Mai (unknown)	iden Surname)	
Mary	d 2 sho th and i 7 is ma trauma		19a. Informant's Name/Relationship (Paula K. Queen (-		-			ity or Town, State, Zi	,
Baltimore,	ages 1 an ent of Heal it; If item 2 y or other		20a. Method of Disposition 14 Burial 2 Cremation 3 C 4 Donation 5 Other (Specia	Removal from State	b. Place of Dispo cemetery, crea	sition (Name of matory or other pla	ce)	Date 200	c. Location - City or T	оwп, State
Baltir	permit. F Departme Importan any injur once.		21. Signature of Funeral Service Sice		22	2. Name and Addre			lington, in Funeral wood, MD	
	Physician	8 1	23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line. _aAlzheimer's			ng, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner	ų,	resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a cor b. Hypertensic Due to (or as a cor	n					
8760,	cate be executed physician and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Arrythmia Due to (or as a cor						
P.O. Box 68	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliv Month	rery Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions of Dysphagia	contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		co use contribute to	the cause of death? bably 4 X Unknown
Vital Records,		Completed by						24a. Was an autopsy performa 1 Yes 2	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	Hospital:		t all pos Oth		th (Check only one)		
1 Or	ding Phys h. After this funeral di	n: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o Injury	IL 3[] DOA	y at	ome 5 ☐ Residence 28d. Describe how	e 6 Other (Speci	fy)
Division	l or Attending after death. Director: After	Certification:	1 Accident 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not b determined	1	At home, farm, str	M 1 🗆	Yes 2 ☐ No	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the I	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	ysician: To the best of my niner: On the basis of exal and manner stated.	knowledge, deat nination and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the caus irred at the time, date	se(s) and manner as	stated. to the cause(s)
	To the comple	Me	29b. Signature and title of certifier	enge		29c. Licens D 198			Date signed (Month)	Day, Year)
J.	Sta	ite_	30. Name and address of person who R. Naeem, MD 1. 31. Date filed (Month, Day, Year)	completed cause of death 5225 Shady G1 32. Registrar's S	ove Road		08 Rock	ville, MD	20850	

DHMH 17 Rev 1/2001

			1 - State Registrar	Cei	tificate of	Death	F	Reg. No. 2	3 11352
1	4 =		1. Decedent's Name (First, Middle, Last)				Date of Dea Month	ath Day Yea	3. Time of Death
in the	Physici /Medic		Lenora Delana Crist				MARCH	27, 2008	10:00A.M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of De	ath
1			Reeders Memorial Home		Boon	sboro		Wash	nington
	Funeral			(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 9. B y, Ye <u>ar)</u>	irthplace (State or Foreign Country)
	Director		218-24-1715 1□M 2XXF	78 Yrs.			Feb. 16,	1930 M	lary land
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	anyla shov d at	-	· ·	**					1XXYes 2 □ No
	e Ma 8a-f	octc	Maryland Washington	St	narpsburg		1	10 000	
	or 2	Directo	10e. Street and Number		10f. Zip Code			10g. Citizen of What (
7	ath v	ra	215 West Chapline Street			1782		US 14 Bass As	SA merican Indian,
(5	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Madical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ M	ever in U.S.	lf Yes, specify Cub	lisp <i>a</i> nic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, WI	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
5-0036	hour al Ex	b H	15. Decedent's Education	16a Dece	dent's Usual Occup	ation		16b. Kind of Busines	
7 5	n 72 ''na	Completed	(Specify only highest grade completed)	(Give	kind of work done DO NOT use retired	during most of work d)	ing		,
-2	withi ene. than	μď	Elementary/Secondary (0-12) College (1-4or 5-	+)		ical Nurs		Mec	lical
Q Q	filed Hyg sther	Ü	17. Father's Name (First, Middle, Last)	TE TOOMS	JCG 11 GO?			Maiden Surname)	1001
→ E	d be ental ked c	To Be	Broun Grove			Mina V	irainia	Wilson	
VAME: ORIST Baltimore, Maryland 21	should M mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street			er, City or Town, State	, Zip Code)
OB	nd 2 Ith a 27 is		Clarence A. Crist, Jr So	n 16862	Bakersv	ille Rd.	Boonsho	oro, Maryla	and 21713
.\ e	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b. Place of Dispo		1	Date	20c. Location - City	
M 5	ages ent of t: If i		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1	Mt. View			1 2008	Sharnshuro	, Maryland
€ \=	artme artme ortan Injur		21. Signature of Funeral Service Licenses			merfælity Hom			i, Haryrano
Ba	Dep Dep any any		1.71				•		+, MD 21795
Z	* 4		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin						Approximate
									Interval Between Onset and Death
	Physician /Medical		resulting in death)	- Silers	دی کی	also Var	hlen	2 nen	7-
	Examiner		Due to (or as a	a consequence of):					
		<u>_</u>	Sequentially list conditions, b. Due to (or as	a consequence of):					Ī.
0.00	ted nsit	i.	Sequentially list conditions, if any, leading to immediate cause. Litter Unserlying Cause (Disease or injury that initiated events c.						1
	ertificate be executed Jing physician and se as the burial-transit	Examiner	resulting in death) Last c. Due to (or as a	a consequence of):					
9	siciar buris								
68760.	ficate phys	/Medical	d						
×	0 9 2		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		_			23d. Date of	delivery
Bo	atter for t	ciar	in the past 12 months?		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		Month	Day Year
P.O.	the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown						_
۵	that led by deta	by Physician	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	tobacco use contribute	e to the cause of death?
<u>5</u>	uires sign ld be	db	Parkingin Duran	sigher:	a sun	men	1 🗆	Yes 2□No 3□	Probably 4 Laknown
Ö	w req beer shou	Completed					24a, Was	an 24b. Were	autopsy findings available
P	has ge 2	m					auto	psy prior death	to completion of cause of
<u></u>	n: The ficate r, page	ပိ	OS Marian de material					2 □ No 1 □ Y	es 2□No
₹	Physician: The law requires that the death this certificate has been signed by the atterral director, page 2 should be detached for the	Be .	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 3 DOA Oth	26. Place of Dear			
ō	Phy rthis	F.	27. Manner of Death 28a. Date of Inju			4 L9-rarsing H		dence 6 Other (S	pecify)
-	Attending r death. ector: A rer	ion	1 Natural 5 Pending (Month, Day	√ Year) Injury	Wo	rk? Yes 2			
<u>:8</u>	death death ctor: / the	cal	3 Suicide 6 Could not be 280 Blace of init	ا ury - At home, farm, st			28f. Location (Street and Number or	Rural Route Number.
Division or Vital Records.	afer Direct	Certification: To	4 Homicide determined building, etc	c. (Specify)	, , ,		City or To	wn, State)	
	pital ours eral filled	ŭ	29a. Certifier 1 Gertifying Physician: To the best	of my knowledge dea	th occurred at the ti	ime, date and place	and due to the	cause(s) and manner	r as stated
	Hos 24 hc Fun	Medical	(Check only one)	f examination and/or in					
	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the tit.	Mec	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Me	onth, Day, Year)
	F 3 F 8		-act mo		DIS	0 (9		muzcu:	
				a a th / (tha 0.0) / (T	Deint)				
	111 7	1	30. Name and address of person who completed cause of d	eatn (Item 23a) (Type,	Print)				

State

DR. VASANT DATTA, 34 31. Date filed (Month, Day, Year) MAR 2 8 2008

340 MILL STREET, HAGERSTOWN, MARYLAND 21740
2008

Registrar

301-739-7100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#8 • Per:Informent PGC3-31-08cr Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 5 20 PM Month Roosevelt Campbell, Jr. 2000 MARCH 20 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | And Youth, Day, Year) | 10/04/1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 **3**M 2 □ F 75 238-42-6254 Chesterfield, S.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Md. P.G. Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8562 Hanover Parkway 20770 U.S.A. 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Cook U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roosevelt Campbell, Sr. Lottie Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan R. Campbell/Son 8952 Continental Pl., LANDOVER, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Livingston Chapel Cem. 3/29/08 Hamlet, N.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 and Jrall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EMPHYSEMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner requires that the death certificate be executed burial-transi and Box 68760, physician the as attending for use P.0. the þ signed t Records, The law has page 2 certificate Division or Vital

Examiner Physician/Medical \$ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I. Certification:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified a once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Roberett

31. Date filed (Month, Day, Year MAR 2 5 2008 State Registrar

4 Homicide

29b. Signature and title of certifier

29a. Certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar		Cei	rtificate of	Death		Reg. No.	nna	1135
	Physici		Decedent's Name (First, Middle, La: Harvey James		ndler "J	r.		2. Date of D March	_	2008	3. Time of Death 12:00 Av
	/Medio		4a. Facility Name (If not institution, giv. 5008 Wheeler Roa			4b. City, Town, Oxon Hi	or Location of Deat	h		unty of Death	
	Funeral Director			ex	rs. last birthday) Yrs.	If Under 1 Year Months Days			irth -1930	9. Birth Virg	place (State or Foreign ntry) ilina, VA
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Prince (Cify, Town or Lo	1			10a Citizan	of What Cou	10d. Inside City Limits 1 Yes 2 No
	th with t 23a or 2 ust be n	Funeral Director	10e. Street and Number 5008 Wheeler Ro	pad		10f. Zip Code 20745	5 -3740		_	d Stat	•
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 1 4 9 9 9 19 5 19 5 19 9 19 19 19 19 19 19 19 19 19 19 19 1	0 –	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)		Race - Ameri Black, White, pecify: Bla	etc.
0-6171	within 72 ho iene. than "natur ihe Medical.]	Completed	15. Decedent's Et (Specify only highest grade Elementary/Secondary (0-12)	lucation ide completed) College (1-4or 5+)	(Give		pation e during most of wo ed) anic Engi		U.S.		ndustry ng Office overnment
ומווח ל	uld be filed Aental Hygi rked other tic event, t	To Be Co	17. Father's Name (First, Middle, Last, Harvey J. Chandle		1		18. Mother's Na Essie B			rname)	
, IMai y	and 2 shore ealth and Normanastrauma		19a. Informant's Name/Relationship (Katie M Chandler	- Wife	5008	Wheeler	t and Number or R	Hill,	MD 207	45-3740)
parminore	Pages 1 nent of Hu ant: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specil</i>	Inemoval from State F	b. Place of Dispo cemetery, cre ort Lind	osition (Name of matory or other pla coln Ceme	etery 3/2	Date 6/2008		ion - City or T twood ,	
Dall	permit. Departr Importa any Injo		21. Signature of Funeral Service Con-	dee	22		ess of Facility For adensbury				
	Physician		23a. Part1. Enter the diffuse, or offi- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line. Coronary			ing, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death 8 Years
	Medical Examiner bhysician and sthe burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Congestive Due to (or as a cons	e Heart	Failure					Years
.O. DOX 0	Da B	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	□Ectopic pregnand □ Other (specify) _	су		23d	I. Date of delive Month	very Day Year
ָרֻ הַ	ires that signed b	by	Part II. Other significant conditions of		resulting in the u	nderlying cause gi	iven in Part I.	100			the cause of death?
ı necolus,	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Completed	Cerebral Vascul Prostate Cancer					24a. Wa	is an 2 copsy formed?	24b. Were aut	opsy findings available ompletion of cause of
A II a	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		ot so lot	26. Place of De	ath (Check only	one)	1	
	nding Phy th. r: After this e funeral d	ition: To	27. Manner of Death 11 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Inju	4 Lu Nursing i	dome 5 Re 28d. Describe	sidence 6 L e how injury o		<u>fy)</u>
	tal or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - A building, etc. (Sp.	t home, farm, sti ecify)	reet, factory, office	•	28f. Location City or T	(Street and Nown, State)	lumber or Rui	ral Route Number,
	he Hospit n 24 hour he Funer pletely fills	edical (29a. Certifier (Check only one) Certifying Physics nysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the overtigation, in my	time, date and place opinion, death occ	e, and due to the	e cause(s) ar e, date and pl	nd manner as ace, and due	stated. to the cause(s)	
	Something of the second	M	29b. Signature and title of certifier	m ND			47654		29d. Date s 3/20/	igned (Month 2008	, Day, Year)
2	3/+1		30. Name and address of person who Charlotte Dea	completed cause of death (n, MD 1.	ltem 23a) (Type, 10 Irvir	Print) ig Street	: NW GB-1	0 Wash	ington	, DC 20)010
is.	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 5 2008	32. Registrar's Si		,					
DHI	MH 17 Rev 1/2		MILLIAN D FOOD	poeur st	March		1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAR 17 **Physician** 2008 ROBERT NORMAN DUNHAM 7:00 P^M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth 07/12/1917 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 90 475 40 7836 Wyoming Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits VA Fairfax NONE 1 X Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22030 USA 3609 Colony Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1934-11. Marital Status Black, White, etc. 1 XIXes 2 No. 1955 If Yes, Give 1955 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Officer US NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Claude Edgar Dunham Ina May Hodges permit. Pages Department of H Important: If Ite any Injury or of

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and if I fem 27 is marked other than "natural", or Items 23a or 28a-f show ant; If I fem 27 is marked other than "natural", or Items 28a-b notified at ury or other traumatic event, the Me-Alcal Examiner must be notified at

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examine ours after death.
neral Director; / within 24 hours Fo the Funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	19b.	Mailing Address (Street and No	umber or Rural Route Nu	mber, City or Tow	n, State, Zip Co	nde)
	3	609 Colony Rd/	Fairfax VA	22030		
		Disposition (Name of y, crematory or other place) ton Nat'1 Cem	Date 5/14/08		n - City or Town gton VA	, State
21. Signature of Funeral Service Licensee		22. Name and Address of F Advent Funer Falls Church	acility al Services VA 22046			
Immediate Cause (Final disease or condition a. SEP resulting in death)		ot enter the mode of dying, suc		y arrest,	ln	oproximate terval Between nset and Death
if any, leading to immediate Due to cause. Enter Underlying Cause (1) and the cause	(or as a consequence of					
in the past 12 months?	birth 2 Fetal death	3 Ectopic pregnancy 5 Other (specify)			Date of delivery Month Da	y Year
Part II. Other significant conditions contributing to	death but not resulting in	the underlying cause given in F		id tobacco use co		
			24a. W a p	erformed?	o. Were autopsy prior to compl death?	r findings available etion of cause of ☑ No
25. Was case referred to medical		26. F	Place of Death (Check or			
1 Yes 2 No Hospital:	Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4	☐ Nursing Home 5☐ F	esidence 6 🗆 0	ther (Specify)	
1 Natural 5 □ Pending (Mo 2 □ Accident investigation	of Injury 28b. T oth, Day Year) Ir	ime of Jack Injury at Work? M 1 ☐ Yes	28d. Descri	be how injury occ		
3 Suicide 6 Could not be determined 28e. Plac build	e of injury - At home, fai ling, etc. <i>(Specify)</i>	m, street, factory, office		n (Street and Nur. Town, State)	mber or Rural R	oute Number,
(Check only 2 Medical Examiner: On the	basis of examination and	death occurred at the time, da daylor investigation, in my opinion	te and place, and due to , death occurred at the ti	the cause(s) and me, date and place	manner as state e, and due to th	ed. e cause(s)
29b. Signature and title of certifler	mo.	29c. License numl 0101243	203 (VA)	29d. Date sign	ned (Month, Da	y, Year)
30. Name and address of person who completed can	se of death (Item 23a) (Type Print) NATT	ONAT. NAVAT.	MEDICAL.	CENTER	

DHMH 17 Rev 1/2001

State

Registrar

HANS C.

31. Date filed (Month, Day, Year)

ACKERMAN

MAR 2 4 2008

M.D.

April

BETHESDA MD 20889-5600

Physician P.O. Box 68760.

Maryland 21215-0036

Baltimore,

Certification: To

this After death

Division or Vital Records. Physician: Hospital or Attending 24 hours after death Funeral Director: filled in by the

completely within 2

State Registrar

Medical

5 Pending

investigation

6 Could not be determined

8182

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

🛮 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month. Dav. Year)

MARCH 24, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD GEORGE 7500 HANOVER PARKWAY SUIT 101 GREENBELT, MD 20770

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

MAR 2 5 2008

28a. Date of Injury (Month, Day Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For amend #23a	State of Maryland Per Phy G878 4,	1 / Depa /17 <i>6</i> 08	rtment of H	ealth and D <i>eath</i>	d Mental Hy	giene2 { Reg. No.	0 8	1 357		
			Decedent's Name (First, Middle, Last)				2. Date of De	onth Day Year					
ŝį.	Physicia	_	Sonya Veronica			Euell M							
/Medical Examiner			a. Facility Name (If not institution, give street and number)			4b. City, Town, or	ath	4c. County of Death					
		Southern Maryland Hospital				Clin		Prince Georges					
¥.	Funeral		Social Security Number 6. Security Number	Пм эМ Е	**	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, Da	ay, Year)	9. Birth Cou	place (State or Foreign intry)		
Ь	Director		215-36-4886	68	Yrs.			12/22	/1939	Wash	nington DC		
	and	Director	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits		
	Maryl f sho ied a		Maryland Prince Georges Upper Marlboro ¹™Yes 2□No										
	the 28a notif		10e. Street and Number			10f. Zip Code		10g. Citizen o	of What Cou	intry?			
	3a or	Ö	9900 Old Indian Head Road			207	72	Ū,	SA				
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?			Was Decedent of H	ispanic Origin?	o- 14. R	ace - Ameri				
9	after or ite nine		1 Never Married 2 Married	1 □Yes 2 X No	1 □ Yes 2 X No		1 ☐ Yes 2 🛣 No Specify:			Black, White, etc. Specify: American			
8	ours r	d by	3X Widowed 4 ☐ Divorced	Year or Dates:	TESTOS ZEPTOS SPESIA,					Indian			
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. if Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occupation (Give kind of work done during most of working			working	1	Kind of Business/Industry partment of			
2	vithin ne. han '	d m	Elementary/Secondary (0-12) College (1-4or 5+)		life. DO NOT use retired)				1 -				
2	Hygie Hygie Ther t		12 17. Father's Name (<i>First, Middle, Last</i>)		Manager 18 Mot		18. Mother's N	Mother's Name (First, Middle,		Defense Maiden Surname)			
and	d be fantal l	Be		Н	Brow	m	Mary	Pea	•	,	tisaw		
Maryland 21215-0036	thould the mark mark	은	Joseph 19a. Informant's Name/Relationship (Brown 19b. Mailing Address (Street)					·			
Baltimore, Ma	nd 2 sulth ar		Vera Drake		7611	Millia	an Lan	ne Clint	on Ma	rylar	nd 20735		
	s 1 a of Hea item othe		20a. Method of Disposition	Ce	ace of Dispo	sition (Name of matory or other place	e)	Date	20c. Location	n - City or T	own, State		
	Pages nent of h int: if ite		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	Removal from State		ction	· .	26/08	Clint	on, Ma	aryland		
a E	permit. Page Department c Important: if any injury or once.		21. Signature of Funeral Service Licer				ss of Facility	dams Fi	neral	Home	e PA		
œ	De la la la la la la la la la la la la la		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral Home PA 20605 Aguasco Rd. Aguasco, Maryland 20608										
	-		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heard failure. List only one cause on each line. Ovarian Cancer Approximate Interval Between Onset and Death										
	Physician												
	/Medical	resulting in death) Due to (or as a consequence of):											
Ь	Examiner	_	Sequentially list conditions,	b. Due to (or as a consequ									
	ed isit	ine	if any, leading to immediate cause. Enter Underlying	uence of):									
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C										
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687	ficate y phy:	Physician/Medic											
X	eath certific attending p for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnar			23d. i	23d. Date of delivery Month Day Year					
. Box	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 D No		3 □Ectopic pregnancy 5 □ Other (specify)				Day Year				
Vital Records, P.O. Box 68760,	that the de led by the a detached t	hys	9 🗆 Unknown	9∐Unknown									
	uires tha signed d be del	by F								Did tobacco use contribute to the cause of death?			
	w requir been si should	ted	1) Obeth Pro Colo						1 Yes 2 No 3 Probably Unknown				
ec	e law I has be je 2 sh	ple	Dypatients or						opsy	topsy findings available ompletion of cause of			
		Completed	Reap) For m Store 13						performed? death? Yes 2 No 1 ☐ Yes 2 ☐ No				
Vita	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		Death (Check only	only one)				
	Phys this (2	1 ☐ Yes 2 No 27. Manner of Death	Inpatient 2 L	ER/Outpatier 28b. Time o	IL 3 DOA	4 LI Nursin		ne 5 ☐ Residence 6 ☐ Other (Specify) 8d. Describe how injury occurred				
Division or	Attending Physician: The la pr death. rector: After this certificate has by the funeral director, page 2	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	of 28c. Injury at 24 Work? M 1 ☐ Yes 2 ☐ No		20d. Describe	now injury occ	Juliou				
<u>is</u>	Atten deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of injury - At hor						mber or Ru	ral Route Number,		
2	al or a	Certification:	4 ☐ Homicide determined	building, etc. (Specify)				City or Town, State)			·		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	o the ithin 2 o the omple:		and mainter stated.							signed (Month, Day, Year)			
	F≯Fö									nov 20,2008			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
7	35		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tho mas Lossed Son MA Description Description										
7	Sta	State 31. Date filed (Month, Day, Year) 32 Fegistrar's Signature											
		Registrar MAR 2 5 2008 Street & Species											

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2 0 8 3 5 8											
	77	Decedent's Name (First, Middle, L.	ast)	2. D				. Date of De	ate of Death 3. Time of Death				
Physici /Medi		GLENN	CEWIS	EXMONISON			\ \ \	Month A A CI	Day 2	Year Lucs	06	43 M	
Examir		4a. Facility Name (If not institution, gi		4b. City, Town, or Location of Death				4c. County of Death					
A **		Howard County C			Columbia					oward			
Funeral Director		579-20-0939	1 PM 2 F F	(In yrs. last birthday) If Under 1 Year If Under 1 Year Months Days Hour			Min.	Date of Bir (Month, Dau 1971).	y, Year)				
and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Insi	de City Limits	
Mary -f sho	호	MD Prince George's Upper Marlboro									1 🗆	Yes 2 No	
h the or 28a or noti	Director	10e. Street and Number 10f. Zip Code							10g. Citizen	of What Cou	ntry?		
23a c 23a c ust be	al	9305 Midland Turn 20772							τ	USA			
er dea tems	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	U.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex			anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)			 14. Race - American Ind Black, White, etc. 			
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by F	1 Never Married 2 Married 3 Midowed 4 Divorced	1 ZYes 2 □ No If Yes, Give Year or Dates: WWT	1					Specify: White				
72 hours "natural";		15. Decedent's E	ducation	16a. Decedent's Usual Occupation					16b. Kind of Business/Industry				
be filed within 72 ho tral Hygiene. Id other than "natulevent, the Medical	ple	(Specify only highest gas Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)									
filed will Hygien ther than	Completed	12		Poli	ce Office					rict o	f Co	lumbia	
be filed ntal Hygi ed other event, til	Be	17. Father's Name (<i>First, Middle, Last</i>) Leonard Edmondson					18. Mother's Name (First, Middle, Maiden Surname) Lillian Evans						
12 should be 1 n and Mental I Is marked of	ဥ	19a. Informant's Name/Relationship		10b Mailie	Address (Street s				lumber, City or Town, State, Zip Code)				
ie, ividity fidilut 2.12.13-0030 stand 2 should be filed within 72 hours af ffeaith and Mental Hygiene. Item 27 is marked other than "natural", or other traumatic event, the Medical Exami		Eileen Tedesco/			2117 Autu					i.11s, 1		1054	
of Health fitem 27		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	9)	Dat	е	20c. Location	on - City or T	own, Sta	te	
permit. Pages Department of Important: If is any Injury or once.		1 X Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Bernoval from State		ction Cem		26/2	800	Clinto	on, MD			
DCITITIONE, permit. Pages 1 ar Department of Hea Important: If item any Injury or othe		21. Signature of Funeral Service Lice	1500 J \$	22	2. Name and Addres	s of Facility	Bea	11 Fur	eral E	Home			
		Merin Korlder 6512 NW Crain Hwy. Bowie											
Physician /Medical		23a. Pa 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. My 0 < 4/	LDIAL					rrest,		Approx Interva Onset	kimate Il Between and Death	
Examiner			b. Due to (or as a consequence of): Due to (or as a consequence of): c.										
	ner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury											
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ificate be execut g physician and as the burial-trar	E	resulting in death) Last Due to (or as a consequence of):											
physicate physicate	edical	5 d											
ding se a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy						23d. Date of delivery				
0 0	by Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown							200.	Month Day Year			
requires that the	y P	Part II. Other significant conditions	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did t	obacco use o	contribute to	te to the cause of death?		
w requires that been signed I	ed b								1 Yes 2 No 3 Probably 4 Unknown				
law r las be	Completed							24a. Was		4b. Were aut	opsy find	ings available of cause of	
The cate ha	5							perfo 1∐ Yes	rmed?	death? 1 ☐ Yes	No.		
Iclan Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Tou.		of Death (Check only o	ne)				
ding Physician: The lava After this certificate has funeral director, page 2	2	1 No 2 No 27. Manner of Death						g Home 5 ☐ Residence 6 ☐ Other (Specify)					
Attending r death. ector: After oy the funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	rat ? ′es 2∐No		28d. Describe how injury occurred					
To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled.	Certification:	3 Suicide 6 Could not t 4 Homicide determined	6 380 Bloco of injury. At home form street factors office					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
oital ours af													
e Hos 24 ho Frunc etely fi	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date									and manner as stated. place, and due to the cause(s)			
Fo the Mithin Fo the	Me	29b. Signature and title of certifier	29c. License number				29d. Date signed (Month, Day, Year)						
(0)		10057051							MAR 22 2008				
V41		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
- []		Walter Atha, MD		m	Columbia	, MD 2	1044						
Sta		31. Date filed (Month, Day, Year) MAR 2. 5. 2008	32. Registrar's Sign	ature									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9879 5-1-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 3. Time of Death Viola Engle 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Florence** Day 2008 Month **Physician** 6:12 p Apr Florence /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frostburg Assisted Living At Frostburg Village Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea 4 - 16 - 1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** PA 86 Director 176-16-1106 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 □★lo Director MD Frostburg Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532 USA 100 Village Parkway Apt. 120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:white þ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Cafeteria Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene McVay William M. Romesburg 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1140 The Terrace, Hagerstown, MD 21742 David A. Engle/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Crown Hill Burial Park 4-7-2008 Vienna, OH 4 ☐ Donation _5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A. for 21. Signature of Funeral Service Ligenses Roberts-Clark Funeral Home, Warren, Ohio Approximate Interval Between Onset and Death 23a Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 years **Physician** disease or condition resulting in death) CONCESTIVE HEM /Medical Due to (or as a consequence of): Examiner Valvulow HEAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner y physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: : After this certific e funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M death. 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26907 Apr 2, 2008

State

Registrar

Harjit S. Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, MD 21502

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** WILLIAM SWEET EICHELBERGER JR 03 2008 0210 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/08/1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min. 1**XX**M 2□ F 80 PENNSÝLVANIA Director 188-20-9832 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at XXYes 2 No Director MD ALLEGHANY LAVALE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 16 HELMAN DRIVE 21502 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Never Married XXX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo WHITE Specify: ģ Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) be filed within 7 all Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 QUALITY ASSURANCE SPECIALIST PAPER MILL INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental I and 2 should be WILLIAM SWEET EICHELBERGER SR HORTENSE (BENTON) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra GLADYS EICHELBERGER / WIFE 16 HELMAN DRIVE, LAVALE, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a, Method of Disposition 1 XXurial 2 □Cremation 3 □Removal from State 03/27/2008 4 ☐ Donation 5 ☐ Other (Specify) FOCKLER CEMETERY SAXTON, PA 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityZIMMERMAN & SON FUNERAL HOME INC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 45 SOUTH CARLISLE ST, GREENCASTLE, PA 17225 Approximate Interval Between Onset and Death DAYS Immediate Cause (Final **Physician** MULTIPLE ORGAN FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE 5 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of requires that the death certificate be executed DESSIMINATED INTRAVASCULAR COAGULOPATHY 5 DAYS and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RESPIRATORY FAILURE, ACUTE MYOCARDIAL INFARCTION 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an RHABOOMYOLYSIS autopsy page certificate 1□ Yes 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1x Inpatient 3□ DOA P 2 ER/Outpatient 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred Medical Certification: To the Hospital or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours a er death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Tous to and 17-14865 22ams 30. Name and address of person who convicted cause of death (Item 3a) (Type, Print) RODUSTIANO J. BARRERA SUITE 201, CUMBERLAND, MD 21502 500 MEMORIAL AVE.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Henrietta Faulkner /Medical 4b. City, Town, or Location of Deat 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** Year) Days Months 1 ☐ M 2 🛣 F 70 1938 West Virginia 217-34-8057 22, Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State "natural", or items 23a or 28a-f show dical Examiner must be notified at Cambridge 1X Yes 2 ☐ No Dorchester Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21613 433 Willis Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) picture fitter publishing permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If them 27 is marked other the any Injury or other traumatic event. the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sadie Massev Roy Bryan Sizemore ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 433 Willis Street, Cambridge, MD husband Jesse Faulkner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 3/26/08 Cambridge, MD Dorchester Mem. Park 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatu Funeral Service Licensee 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oneumon/a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and thed for use as the burial-transit Due to (or as a sensequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy After this certificate has been signed by the atte funeral director, page 2 should be detached for in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? es 2 DNo this certificate 2 No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Dramble

Cambridg My

30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)

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2008

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32 egistrar's Signature

3110 Gracefield Road Silver Spring, Maryland, 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ANNE FOOTER 03/18/2008 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Pototmac If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 💢 F 578-09-6591 Washington, DC Director 1/15/1913 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 X Yes 2 No Rockville Director Montgomery 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 20851 U.S.A. 620 Marcie Lane Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ural", or item Black, White, etc. Pages 1 and 2 should be filed within 72 hours after anent of Health and Mental Hygiene. an enter of Health and Mental Hygiene. It is then 27 is marked other than "natural", or its uny or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine ury 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sara (Unknown) Samuel Levin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 Is
any Injury or other trau 2744 Hunters Gate Terrace, Silver Spring, MD 20904 Sara F. Rohde - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State King David Mem Gdns 103/20/2008 Falls Church, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, MD 21. Signature of Funeral Septice Licenses 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9□Unknown 9 Unknown by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 certificate 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054566 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Sunita ia Arrhy

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Registrar

31. Date filed (Month, Day, Year)

MAR 2 5 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 4:45 рм Amanda Caroline Fisher 2008 16 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL INSTITUTE OF HEALTH BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2□ F 238 41 5599 38 Director NOV SC Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State show ns 23a or 28a-f shormust be notified at 1 ☐Yes 2 ☐ No Director WAKE RALEIGH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 PACES FOREST COURT 27612 US by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Examiner permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE MOSES CONE HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS C. FISHER ELIZABETH BANE ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH CAMERON MOTHER 505 WEST MORGAN STREET WADESBORO, NC 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREM. Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State MARCH 19 2008 4 ☐ Donation 5 ☐ Other (Specify) ĂLEXANDRIA, VIRGINIA 4217 9TH STREET, NW 22. Name and Address of Facility 21, Signature of Funeral Service Licenses MARSHALL"S FUNERAL HOME , DC WASHINGTON, DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Renal Acuto /Medical Due to (or as a consequence of): days **Examiner** tulminuint Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed days SCPTIC Due to (or as a consequence of): ivision or Vital Records, P.O. Box 68760, Physician/Medical MONTH Rospirator IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Adhesion delections 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown LCUKOGITC Be Completed HYPER KALEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 \(\square\) No ANEMIA Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the I 29c. License number 29b. Signature and title of certifier AFE 84136 30. Name and address of p. rson who completed cause of death (Item 23a) (Type, Print) 10 Kai 10 Center Dr., Bethesda, MD 20892 31. Date filed (Month, Day, Year) State 5 MAR 2 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year **Physician** March 22, Lessie Finch 4:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ft. Washington Health & Rehab. Fort Washington Prince Georges If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Aug. 26, 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1X M 2 ☐ F 89 243-16-3711 1918 Lucama, NC Director Usual Residence of Decedent 10a. State 10b. County Ioc. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Prince Georges Fort Washington 1 ☐ Yes 2 No Director $^{10e.\,Street\,and\,Number}$ 10800 Indian Head Highway, #G1910g. Citizen of What Country? 10f. Zip Code 20744 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🖸 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private Industry permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other i any Injury or other traumatic event, <u>th</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Finch Martha Ann Bynum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 44 Lillie Mae Finch - wife 10800 Indian Head Highway, G19, Ft. Washington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 3-28-2008 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signator e of Funeral Service Ligense 22. Name and Address of Facility Bell & Johnson Funeral Home, P. A. 6503 Old Branch Ave., Temple Hills, MD 20744 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. And 1. Enter the dis shock, or heart failu Imm. date Cause (Final disease or condition resulting in death) **Physician** THEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 1 ☐ Yes 2 ☐ No 9☐Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? , GANGRENE 24a. Was an has autopsy performed? (es 2 No page RENAI certificate INSUFFICI EMENTIA 2 🗆 No 1∐ Yes 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the rusperses within 24 hours after death.

To the Funeral Director: After this of the funeral directors and the funeral directors. 2 ER/Outpatient ٩ 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 [Yeartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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State Registrar 29b. Signature and title of certifier

Date filed (Month, Day, Year)
MAR 2 5 2008

ERGHESE 11701 32. Registrar's Signature

HYSICIAN

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIVING-STON ROAD SUITE # 101, FORT WASH

29d. Date signed (Month, Day, Year)

29c. License number

D53782

State Registrar 29b. Signature and title

12080 010

certifie

32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

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Terri L	Finch

erri L. Finch		State of Maryland / Department of I				ible.	
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Physicia	n/	1. Decedent's Name (First, Middle,Last)			2. Date of Death	· · · · · · · · · · · · · · · · · · ·	3. Time of Death
ledical Examin ├─		Terri L. Finch			Month March 26, 2		1429 hrs
	п		o. City, Town, o Brandywine	r Location of Death		4c. County of Deat Prince Georg	
Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Yea		8. Date of Birth	n(MM/DD/YYYY) 9. Bi	
Director		578 88 6665 1□M XXF 46 Yrs.	Months Day			Forei	
	ŀ	Usual Residence of Decedent			May 18.	, 1961	,, , , , , , , , , , , , , , , , , , , ,
v any	Γ	10a. State 10b. County 10c. City, Town or Location		· -		· · -	10d. Inside City Limits
laryland 8a-f show at once.	٥	Maryland Prince George's Brandywi					1 Yes 2 XXNo
r 28a	Director		10f. Zip Code		10	g. Citizen of What Cou	
章 23		9009 Robinson Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was		513 ispanic Origin? (S pe	cify Ves or No-	United S	rican Indian, Black,
rs after death w ural", or items	Funeral	1 Never Married 2 XX Married Armed Forces? If Yes	s, specify Cuba	n, Mexican, Puerto F	Rican, etc.)	White, etc.	incan indian, black,
fter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year XX 1	Yes 2 <mark>X</mark> X No	o specify:		Specify:	White
ours a	g D			ation (Give kind of we e. DO NOT use retire		16b. Kind of Business	/Industry
n 72 h	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	_	e. DO NOT use reure	,	Own Hom	ie
withi giene.	<u>ا</u>	Homema:	ker	18.Mother's Name	First Middle M		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be C	Ralph Edwards			ta Rich	·	
213 ould b d Men s mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Stre	eet and Number or R	ural Route Num	ber, City or Town, Stat	e, Zip Code)
MD 1d 2 sho lith and m 27 is aumati	1	Henry Finch (Husband) 9009	Robinso	n Street.	Brandy	wine, MD 2	0613
ore, se l an of Heal If iter		20a. Method of Disposition 20b. Place of Disposition Removal from State 20b. Place of Disposition crematory or other	er place)		Date	20c. Location - City of	
iment or oth	4	4 Donation 5 Other Specific	tion Ce	metery Ap	ril 1,2	008 Clint	on, MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat injury or other traumatit event, the Medical Exa		21. Signature of Funeral Service Licensee 22. Na	me and Addres	ss of Facility ee	Funeral	Home, Inc6	
Physician	-	25a. Part I. Enter the disease, or complications that caused the death. Do not enter the	e mode of dying	a, such as cardiac or	respiratory arre	inton, MD	20735 Approximate Interval
/Medical		failure. List only one cause on each line.		,	. ,		Between Onset and Death
⁻xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				·• · ·	
	۰	Sequentially list conditions, b					
	[발	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c					
ed sit	Examin	events resulting in death) Last Due to (or as a consequence of):	•				
	dical	d. X UNPENDED X AMENDED 23a, 237, 100 ME / 8878.	5/1/08 an	mh			
60, ate be hysicia e buria	팋	IF FEMALE: 23c. If yes, outcome of pregnancy	J/ 1/ 00 (a)			23d. Date of delive	Prv :
Box 68760, e death certificate bethe attending physical control of for use as the burden by the burd		23b. Was decedent pregnant in the past 12 months?	al death 3	Ectopic pregnar	ісу	Month	Day Year
eath c atten for us	sici	1 Yes 2 No 9 V Unknown 9 Unknown	er (Specify)				
D. B trthe d by the	Physi	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause	given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
P.O.	흵				1 Yes	2 No 3 Pr	obably 4 🗹 Unknown
rds requi	흫				24a. Was a		autopsy findings available completion of cause of
eco he fav ate has	Completed				perfor	med? death?	
tal Rec cian: The certificate ector, page	φĺ	25. Was case referred to medical	26.Plac	ce of Death (Check of	nly one)		
Vit.	8 2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient				Residence 6 🗸 Oth	er: Scene
n of ving Ph	E	27. Manner of Death 1 X Natural Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	jury 28c. Inj	jury at Work? Yes 2 No	28d. Describe h	now injury occurred	
Visior or Attene of Attene of Attene of Attene of Attene	lä:	2 Accident Investigation 289 Place of Injury At home form street	factory office		28f Location (S	Street and Number or F	Rural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been seled in by the funeral director, page 2 should be	Certification:	Suicide 6 Could not be determined (Specify)	i, lactory, office	bullaring, etc.	or Town, Si		to an itotic remoti, only
Hospi 24 hou Funer rely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre	ed at the time,	date and place, and	due to the cause	e(s) and manner as st	ated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	on, in my opinic	on, death occurred a	the time, date a	and place, and due to	the cause(s)
F×Fö	ž	29b. Signature and title of certifier	1	nse number		29d. Date signed (N	•
		Down MUINN 1mis	0.0	S.M.E. 		March 27, 2008	
		30. Name and address of person who completed cause of death (Item 23a)	Penn Street	et, Baltimore, MI	21201		
Sta		Donna M. Vincenti, MD Assistant Medical Examiner 111 31. Date filed (Month, Day, Year) 32. Régistrar's Signature		i, Daillinole, Mi	1201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **2008** Year MARCH 23, **Physician** 01:56A JEAN MARGUERITE JEFFERS GRAVES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner KENT CHESTERTOWN CHESTER RIVER HOSPITAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 ▼ 217-30-9024 73 MD Director 3/16/1935 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Heaith and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1**X** Yes 2 □ No Director MILLINGTON KENT MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21651 USA 318 RACE ST. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DORM MOTHER **EDUCATION** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALICE MARGUERITE CLARK ို **GRAYSON JEFFERS** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AUGUSTINE GRAVES/HUSBAND PO BOX 231 MILLINGTON, MD 21651 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If it any injury or o 3/29/08 PONDTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) MT. PLEASANT 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
370 W. CYPRESS ST. MILLINGTON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION Physician /Medical Due to (or as a consequence of): Examiner DISEASE ARTERY CORDNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and -trar physician and the purial-tr Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical attending p as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION SEVERE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 211 No has certificate 1□ Yes Division or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 FR/Outpatient 3 □ DOA 1 Inpatient 1 🗌 Yes 2 this 28b, Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After Certification: To the Hospital or Attending (Month, Day Year) Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. filled in by the Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral E Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Name and address of person . Chestertown, MD 21620 122 31. Date filed (Month, Day, Year) 32. Registraria Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MFND#23a/bperMD4-1-08, BMW, MbCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) , 2008 Year Jeanne GOLDSTEIN **Physician** March 23, 11:55 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House Montgomery Hospice 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 8, 5. Social Security Number 7. Age (In yrs. last birthday) 1916 Funeral Months Days Hours Germany 92 119-18-3477 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at No Yes 2 No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20016 United States 4000 Massachusetts Ave., NW Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Salon Manager other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F
7 Is marked of
traumatic ever Pages 1 and 2 should be Adele Kronen Julius Marberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14801 Cobblestone Drive, Silver Spring, MD 20905 19a. Informant's Name/Relationship (Type. Print) Ina Goldstein, Niece Health stem 27 l permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tr.
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3-25°-08 1 XBurial 2 □ Cremation 3 X Removal from State Adas Israel Congregation Cemetery Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 1 Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Colitis Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Renal Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 1 □ Yes 2 🕅 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Septicemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No -Hypertension 24a. Was an certificate has t rector, page 2 s autopsy performed? Yes 2V No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Tes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) House 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours af

To the Funeral D

completely filled in 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) and title of certifie 29b. Sign မ March 24, 2008 D 0064615 el/ D

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20855

Génevieve Wrobelewski, M.D., 6001 Muncaster Mill Rpad, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** 2008 21, 8:30 a March Lowe Gibbons Mildred Louise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Bedford Court Nursing Home If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F 3, 1918 Washington, 89 Nov. Director 578-07-5160 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes \$1 No Directo Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 3278 Gleneagles Drive, #1B 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3√ Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Federal Government other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and z sure of Health and Mental rem 27 Is marked o Be Edna Howard John Douglas Lowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trainonce. 11103 Federal Court, Rockville, MD 20853 Thelma Greene/Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 March 26. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4 □ Dorgtion 5 Other (Specify) 2008 Brentwood, Maryland 21. Signature of Fundral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd., W,. Silver Spring, MD 2090 23d. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 2 Years **Physician** Atherosclerotic Cerebrovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) as been signed by the a 2 should be detached 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part il. ģ Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Steroid Dependence, Stroke, Dementia autopsy has page 1☐ Yes 2/3/No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2FXNo 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Attending injury 5 ☐ Pending 1 Natural within 24 hours after occur.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide ō To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of confiner March 26, 2008 D53367 Rajan Shyamsundar, MD 9801 (Hem 23a) (Type, Print) Rajan Shyamsundar, MD 9801 Georgia Avenue, #117, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) State 2 5 2008 Registrar

DHMH 17 Rev 1/2001

08-02145 Nick Germain

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

NICK German	1-For State Certificate of Death Reg No.
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death
Medical Examine	Nickerson Germain Month Day Year 1733 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
-	Prince Georges Hospital Center Cheverly Prince George's
Funeral Director	5. Social Security Number 220–69–5528 6. Sex 1. X M 2 F 24 Yrs. 7. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 24 Yrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 4. Haiti
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
*	1 Yes 2 XNo
the Maryland a or 28a-f sk tified at onc	Maryland Prince George's Bladenshurg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
the M	5800 Annapolis Road, Apt. 110 20710 Haiti
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White, etc.
s after of rall", or ainer in by F	3 Wildowed 4 Divorced in test give tear 1 Test 2 No Specify. Specify.
natur: xami	
5-0036 ed within 72 hour lygiene. other than "natu the Medir at Exan	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Salesperson Retail
-00% 1 with 1 with giene ther the	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 muld be filed within 7 Mental Hygiene. marked other than c event, the Medie	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner To Be Completed by I	
MD at 2 sho tith and m 27 is aumati	Patrick Germain /Brother 419 Covote Trail, Justy, Maryland 20657 20a Method of Disposition 120b, Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
ore, s l ar of Hee If ite	20a. Method of Disposition 1 SXBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 5, Cemetery of Port-au-Prince 2008
Page ment cant:	4 Departing 5 Department Specify: Cemetery of Port-au-Prince 2008 Port-au-Prince, Haiti
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other timportant or other traumatic event, the Mac To Be Com	21. Sign tur of Furier is seven License 22. Name and Address of Facility Francis J. Collins Funeral Home Inc.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line. Between Onset and Death Death
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
	Sequentially list conditions, b
ine ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.
led Insit	(Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):
executed an and al - transical Ex	
760, icate be executed physician and the burial - transit	UNPENDED AMENDED 123c. If yes, outcome of pregnancy 23d. Date of delivery
876 tiffcat ng ph	
Box 687 e death certific the attending p ed for use as the	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown
Records, P.O. Box 687 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as the committeed by Physician!	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O.	
Records, The law require. ficate has been signage 2 should be	24a. Was an 24b. Were autopsy findings available
COrc law re has be	autopsy prior to completion of cause of performed? death?
Refigure	
irector	examiner? Hospital: Hospital: Double of FDO United States of Double of Decidence 6 Other
Division of Vital Records, P.O tal or Attending Physician: The law requires that the predector. After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director.	7 Manuar of Death 289 Data of Jajury 286 Time of Jajury 286 Injury at Work? 286 Describe how injury occurred
on ending ath.	1 Ves 2 No
Vision Attracted in by t	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division or spiral or Attending I hours after death meral Director: After filled in by the funer Centrification.	4 Homicide determined (Specify)
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pompletely filled in by the funeral director, page 2 should be detached for use as the Martical Certification: To Re Completed by Physician.	
F. F.S.	
5	Carol Hallan O.C.M.E. March 17, 2008
	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat	a 31. Date filed (Month Day Year) 326 Registrar's Signature
Registra	MAR 2 5 2008 Beever St. Aparte

DHMH 17 Rev 1/2001 OCME 2006

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			For State Registrar	State o	f Marylan	-	artmen ertificat			and M		giene	2008		372
	Physici	an	1. Decedent's Name (First, Middle								2. Date of De Month	Day	Year	3. Time of	Death a M
~	/Medic		Lawrence L. Go 4a. Facility Name (If not institution		mber)		4b. City,	Town, or	Location of	of Death	3/22	2/2008 4c. C	ounty of Death	7:00	
	LAGIIII		8100 Lakecrest	Dr.				G ₁	reenb			Pr	ince G	eorge's	3
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. I		/) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)		place (State o	
	Director		066-16-5424 Usual Residence of Decedent		88	3					1/27/1	1920	New	York (Sity
	arylan show	-	10a. State 10b. County		10c. City	, Town or L	ocation							10d. Inside C 1⊠Yes	
	the Ma 28a-f	Funeral Director	MD Prince 10e. Street and Number	George's			10f. Zip		eenbe.	lt_		10a Citize	en of What Cou		ZNO
	3a or	iO le	8100 Lakecrest	Drive			101. 219	2077	70			rog. Onizo	U.S.A	•	
	ems 2	ner	11. Marital Status	_	dent Ever in U.	S. 13	. Was Deced			gin? (Spe	ecify Yes or No Rican, etc.))- 14	. Race - Amer Black, White	ican Indian,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinant be redified at once.		1 ☐ Never Married 2 ☐ Marri 3 🖾 Widowed 4 ☐ Divorced		2 🔀 No ⁄e		1 □Yes		Specify:		,		nooifu.	ite	
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ylar	ould be Menta arked aric ev	70	Harry Goldberg			,			Jeni	ny Cl	nayet				
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationsh								al Route Numb			ip Code)	
و ف	is 1 and 2 and 2 is Health a item 27 is		Janet Goldberg 20a. Method of Disposition	, Daugnte			Laked cosition (Nari ematory or o				eenbelt		20770 ation - City or T	own, State	
E O	Pages lent of nt: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		state		ematory or o t_ City		i	3/27	/2008	Green	helt 1	ΔD.	
alti	permit. Departm Importa any inju		21. Signature of Funeral Service		\ /		22. Name an				2000		39 Bal		Ave.
<u> </u>	20 E # 91		Mandett	e Dasc							e, P.A.		attsvi		
E		. 5	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that c only one cause on e	aused the death ach line.	n.Dohrofte	nter the mod	le of dyin	g, such as	cardiac o	or respiratory a	ırrest,		Approximat Interval Bet Onset and	tween
	Physician /Medical		disease or condition resulting in death)	a	icemia oras a consequ	ience of):								Days	
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89	ng phy as th	Medi	IF FEMALE:		-										
Box 6	Attending Physician: The law requires that the death certificate be executed redeath. The Attenthis certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregna pirth 2 Fetal	death 3	☐ Ectopic p		,			23	d. Date of deli		Year
P.0.	that the de ned by the a detached f	ysic	1 □Yes 2 □ No 9 □ Unknown	4 ☐ Pregr 9 ☐ Unkn	nant at time of d own	eath 5	Other (sp	ecify)						5,	
ري ت	signed by	by Ph	Part II. Other significant condition	ns contributing to de	eath but not resu	ılting in the	underlying c	ause give	en in Part I.		23e. Did t	tobacco use	e contribute to	the cause of	death?
Ş	w require been signations beautiful to the signature of t	ed b	Congestive Hea	rt Failur	e						1 🗖	Yes 2 ⊠	No 3□ Pro	bably 4 🔲	Unknown
) Second	e faw r has be je 2 sh	Completed									24a. Was	psv	24b. Were aut	opsy findings ompletion of o	available cause of
<u>=</u>	n: The ficate r, pag										1 □ Yes		death? 1 □ Yes	2 🗆 No	
₹	hysician: The la his certificate ha I director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2 🗆	EB/Qutpati	ent 3 🗆 DC	Othe			n <i>(Check only c</i> me 5 ∑ Resi		Othor (Case		
ر 10	ding Phy h. After thi funeral c	ü	27. Manner of Death	28a. Date		28b. Time Injury	of 2	8c. Injury Work	/ at		28d. Describe			119)	
siol	tendir leath. tor: Ai	catic	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation			М	1 🗆 `	Yes 2□						
	- 하루드	Certification: To	4 Homicide determi	ned 28e. Place buildii	of Injury - At ho ng, etc. (Specif)	me, farm, s	treet, factory	, office			28f. Location (City or To	Street and i wn, State)	Number or Ru	ral Route Nun	nber,
_	To the Hospital of within 24 hours af To the Funeral D completely filled in		29a. Certifier 1 🗵 Certifyin	g Physician: To the	best of my know	wledge, dea	ath occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) a	ınd manner as	stated.	
	the Ho nin 24 the Fu npletel	Medical	one)	Examiner: On the band man	asis of examination of the stated.	tion and/or				th occurr	ed at the time,	date and p	lace, and due	to the cause(s	à)
	with Con	2	29b. Signature and title of certifier	11)	290	. License				29d. Date	signed (Month	, Day, Year)	
	(6)	-	20 Name and address of 30	who completed as	not don't /lta-	29a\ /Tu-	Drint\	D	22780)		Marcl	h 24, 2	8008	
' (ye !		30. Name and address of Person value Peter M. Schis		00 Gree			r	Greer	ibe1t	. MD 2	0770			
	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Signat	ture		,		_~	- 9 1.3.2 (-1	<u> </u>			
	Registr	ar	MAR 2 5 2008	Bleve	KA	reva-	2								

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** George Edward 21° , 2008 Gebhard 8:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 5078 Euclid Street Cheverly 5. Social Security Number 7. Age (In vrs. last birthday) f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-15-1944 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Hours Min Washington, DC 63 Director 213-46-5684 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Cheverly Prince George's Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5078 Euclid Street United States 20785 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1965 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 🗌 No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 1967 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PEPCO Overhead Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George W. Gebhard Doris Haskins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5078 Euclid Street Cheverly, MD 20785 Kathleen M. Gebhard (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 3/27/2008 Brentwood, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 Keehal romo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **months** Pancreatic Cancer **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-trar Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 2 In a 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? this certificate has 2 🗆 No 1∐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ဥ 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation o the Hospital or Attendir ithin 24 hours after death. o the Funeral Director: A М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title_of certifier courte ow (10) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 115 Centerway Steen bolt 010 20770 32. Registrar's Signa 31. Date filed (Month, Day, Year) State MAR 2 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1509 M Anna Gertrude Horst March 22 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Vonchoster DURCHESTER GENERAL CambridGE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🕅 F Months 70 218-34-8781 1937 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 mounts.
Pages 1 and 2 should be filed within 72 mounts of Health and Mental Hygiene.
Irant: If them 27 is marked other than "natural", or items 23a or 28a-f show trant: If them 27 is marked other than "natural", or items 23a or 28a-f show that: If them 27 is marked other than "natural", or items 23a or 28a-f show that it it is not a should be a sho 10b. County 1 X Yes 2 No Director East New Market Maryland | Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21631 USA 1912 Academy Street, Apt. 106 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1∐Yes 2XXNo White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Jones Dorothy Ewing 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra-4811 Covington Drive, Concord, NC Patricia McCabe/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 3/26/2008 Beulah, Maryland 21. Sign tue of uneral Service Lic. Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hemorrhage Intracrania/ /Medical Due to (or as a consequence of): **Examiner** pertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due or as a consequence of) Physician/Medical Examiner physician and strans Due to (or as a consequence of): nding p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown þ signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pulmonale 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Cunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🕱 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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To the Funeral C

completely filled

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Cambridge MD 21613 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Bramble Patricia

🖍s Signature

32. Regist

2008

State Registrar

4 Homicide

31. Date filed (Month, Da

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND#19a/bperFH3/25/08, BMW, McCo Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 19, 7:45PM WALTER HARRIS March 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Clinton Nursing & Rehab. Center Clinton, P.G 8. Date of Birth (Month, Day, Year) 9/03/1925 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Days 1 M 2□F Months Hours 82 Washington, DC 578-26-0124 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 1 ☑ Yes 2 ☐ No MD P.G. Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 708 Irving Street 20745 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 □ No if Yes, Give Year or Dates: 41-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Harris Josephine Washington 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Richardson/Dau 708 Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Vet.Cem. 3/28/08 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral 21. Signature of Funeral Service Licenset 3821 - 14th Street, N.W., Wash., DC 2001 2(a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) Aspriation Due to (or as a consequence of): Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Examiner requires that the death certificate be executed physician and s the burlal-transi

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Examiner

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the Hospital or Attending

Physician/Medical

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Certification:

Medical

Division or Vital Records, P.O. Box 68760,

IF FEMALE:

1 Natural

2 Accident

4 Homicide

3 Suicide

23b. Was decedent pregnant

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

108

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 29b. Signature and title of certifier

Khosrow Davachi,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#409, Clinton, MD

State Registrar 31. Date filed (Month, Day, Year) 25 2008 MAR



DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

25

2008

32 egistrar's Signature

			1- State of Maryland / D	epartment of H Certificate of L			jiene leg. No. 2001	8 1137
	Physici /Medic		1. Decedent's Name (First, Middle, Last) David Cranston Hylton			2. Date of Dea Month March 22	Day Year	3. Time of Death 4:39 a M
	Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or	Location of Death	1	4c. County of De	rundel
	Funeral Director		5. Social Security Number 577-80-8389 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 1	9. Bi 4, 1962 Wa	nthplace (State or Foreign country) shington, DO
ignition of the Marylan and 2 should be filed within 72 hours after death with the Marylan	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 6020 Parkers Creek Drive 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) James A. Hylton	Deale 10f. Zip Code 20753 13. Was Decedent of Hilf Yes, specify Cuba	spanic Origin? (Sin, Mexican, Puerli Specify: ation luring most of wor.) ender 18. Mother's Nam Jane	becify Yes or No- o Rican, etc.) king ne (First, Middle, I E. Dunn ral Route Number	Og. Citizen of What CUSA 14. Race - Arr Black, Wh Specify Whi 16b. Kind of Busines: Real E Maiden Surname) 7. City or Town, State, rksville,	terican Indian, ite, etc. te s/Industry state
permit. Pages 1	Department of He Important: If item any Injury or oth once.		1 Burial 2 □ Cremation 3 □ Removal from State cemetery		e) Marcal Park s of Facility Colling	2008 2008 Funeral	Silver Sp	,Maryland
<i>j. 1</i>	bhysician and street burial-transit street burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due in (or as a consequence of Due to (or as a conseque					Interval Between Onset and Death
the death certifi	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	l Blivery Day Year
requires that	been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the part II. Other significant conditions	ne underlying cause give	n in Part I.	23e. Did tob		or the cause of death?
1: The law	certificate has be rector, page 2 sh	Completed	diabetes			24a. Was al autops perforr 1 Yes 2	y prior to	
the Hospital or Attending Physician:	After this funeral di	Certification: To Be	25. Was case referred to medical examiner? 1	ury Work' M 1 ☐ Y	r: 4 ☐ Nursing H	28d. Describe ho	ence 6 Other (Spots injury occurred	
ne Hospital	within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, and manner stated.	leath occurred at the tim or investigation, in my op	e, date and place, pinion, death occu	and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
Į Į		Me	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (T)	29c. License	number 8510	29	9d. Date signed (Mon	th, Day, Year)
	Sta Registra		31. Date filed (Month) Day, Year) MAR 2 5 2008	AAW	C	Cuy 1	MO	21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** -EROY HACKEY 2008 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 19 33 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1MM 2□F Yrs. Maryland 74 **Director** 21403208527 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Silver Spring Montgomery 1 ☐Yes 2X No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 U.S.A. Glen Allen Ave, #203 2605 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. M Yes 2 No If Yes, Give Year or Dates: 54-57 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery Co Elementary/Secondary (0-12) College (1-4or 5+) Bldg, Service Worker Schools 12th 27 is marked other er traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Gibson William L. Hackey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 0906 2605 Glen Allen Ave, #203 Silver Spring, MD 19a. Informant's Name/Relationship (Type. Print) Barbara B. Hackey (Wife) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Derial 2 ☐ Cremation 3 Removal from State 3/31/08 Cheltenham, MD Veterans Cem 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 ZMG 23a. Part1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small Bowel Obstruction **Physician** /Medical Due to (or as a consequence of): **Examiner** 7 years Abdominal Adhesions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy page ; perform rmed? 2 No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) e of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours a

> State Registrar

31. Date filed (Month, Day, Year) 2 5 2008

30. Name and address of

SARRY

MD Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

11120 New HAMPSHINE PUE #201, S. Wer Spring

DZ1153

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#6, perFH, #11, perTNF, G878, 4/21/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** RENEE HENRY 14,2008 08:39 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 8177 ASPEN WOOD WAY JESSUP HOWARD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2 ▼ F Yrs. 151-38-8372 Director 60 SEP 28 1947 NEW JERSEY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Events. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State XXYes 2 □ No Directo MD HOWARD **JESSUP** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8177 ASPEN WOOD WAY 20794 U.S.A. by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: BLACK Specify 3 ☐ Widowed → Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 vrs Dental Hygienist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERMAN MORRIS ANITA JORDAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MONICA LINDSEY/DAUGHTER 116308 AYRWOOD LANE, BOWIE, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Monmouth Memorial 3/27/2008 Tinton Falls, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the dis ase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due t or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy 01 perform 0 1∐ Yes To the Hospital or Attending Physician: the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No Director; 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title 08 (Item 23a) (Type, Print) 30. Name and address of person

State Registrar 6005

CHEVERLY, Md. 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 162M 2□ F 131-16-5579 82 Director 1925 July 28, New York Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Anne Arundel Gambrills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 2607 Chapel Lake Dr. USA 21054 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No WWII If Yes, Give Year or Dates: 7 Is marked other than "natural", or items traumatic event, the Medical Examiner m 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Credit Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert F. Hanley, Sr. Eugenia Lovenheim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once. Nancy L. Radford/Daughter Glen Burnie, MD 21060 7621 Marcy Dr. 20b. Place of Disposition (Name of Metropolitical) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3/27/2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Crematory | 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons, que ce of): Zile **Examiner** 11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RAICA 4WK 1 Yes 2 No 3 Probably 4 Unknown Completed PVD 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 24 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Impatient Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print)

State

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mar 31, 2008 12:30pm [™] Holmes /Medical Dorothy 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Golden Living Center Cumberland 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex Funeral MD 1 ■ M 2 ■ F Director Jan 14, 1912 215-34-4259 96 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Cumberland 1 TYes 2 No MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 512 Winifred Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify. δ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) registered nurse Doctor's office 12 .. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 is marked other ti ilury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Caroline A. Matt Holmes Presley H. Holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Cumberland 7 Elder Street Ann Palmer niece Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/1/2008 Scarpelli Funeral Home, P.A. MD Cresaptown 21. Signature of Funer of Pervice Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Betwee set and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebro /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 pronths? 1 □ Yes 2 □ No Day 5 ☐ Other (specify) sate has been signed by the a page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled i retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of DOU 3328U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUPTA M. D. 60 UMBERUTNO MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 0 8

2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrer	State of M	arylan		artmen rtificat			ind M	lental Hy	giene Reg. No.	008	11382
	Dhysiai		1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month	aath Day	Year	3. Time of Death
	Physici /Medic		RUBY LEE IRWI	N							March	29	2008	1:05 P M
	Examin	er	4a. Facility Name (If not institution, give)		4b. City,		Location o	f Death		4c. Coi	inty of Death	
			3609 Conowingo R		/l- um	In me to last of a col	If Under	Stre	et If Under 2	24 Hrs	9 Data of Bi	dh	Harfo	ord hplace (State or Foreign
	Funeral		5. Social Security Number 6. Security Number 11	7	90 (<i>in yr</i> s. 75	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di 7/10/1	ay, Year)	Co	t Virginia
U.	Director		Usual Residence of Decedent	21							7/10/1	934	Wesi	c viiginia
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo								10d. Inside City Limits
	Mar.	ţo	MD Harford			Str	eet							1 ☐ Yes 21X No
	th th	Jre.	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Co	untry?
	hours after death with the Maryland tural, or Itema 23a or 28a-f ehow al Examinar must be multified at	Funeral Director	3609 Conowingo R	oad			21	154					USA	
	tem tem	nue	11, Marital Status	12. Was Decedent Armed Forces	?	.S. 13.	Was Dece If Yes, spe	dent of His cify Cubar	spanic Orig n, Mexican	gin? (Sp i, Puerto	ecify Yes or N Rican, etc.)		Race - Ame Black, White	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			1 🖺 Yes	2√2 No	Specify:			Sp	ecify: Wh:	ite
21215-0036	y within 72 hours after death with the Marylar liene. rthan "natural", or itema 23a or 28a-f ehow the Madical Examinat must be civilliad at	edt	15. Decedent's Ed			16a. Dece	dent's Usu	al Occupa	ıtion			16b. Kind o	of Business/	
15	n na n na	Completed	(Specify only highest gra-		£.\	(Give	kind of wo DO NOT u	rk done d se retired,	uring most	t of work	ing			
212	d within giene.	E	8	College (1-40)	3+)	Hom	emake	er				Ow	n Home	e
멀	be filed ntal Hygi od other event, t	Be	17. Father's Name (First, Middle, Last)						18. Mothe	ır's Namı	e (First, Middle	a, Maiden Sui	тате)	
<u>Na</u>	Menta Menta arked	은	Floyd Maynard								Damron			
Maryland	2 shc and is m		19a. Informant's Name/Relationship (7	• • • • • • • • • • • • • • • • • • • •							al Route Numi			Zip Code)
	1 and Heelth em 27 other tr		Wanda L. Cleary/	Daugnter	loop r						creet,		154	Town State
0	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State		Place of Dispo cemetery, crei							on - City or	
Ę	mit. Pa bartmen cortant: injury		4 □ Donation 5 □ Other (Specify		S1	ate Ri					/2008	Delta	, Peni	nsylvania
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Linen	500	1.				s of Facilit neral		ne, Inc	Del	ta. P	A 17314
			23a Part1. Enter the divease, or core	nications that cause	d the deal									Approximate
			shock, or heart failure. List only immediate Cause (Final	one cause on each	line.	4 4	N		1.		Canc			Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a Due to (or a		tatic_	CV	NONE	and	<u> </u>	anc			3 months.
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		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consec	quence of):								11
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Вох	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	aldeath 3[∃Ectopic p ∃Other (s					230	Month	Day Year
0	0 8 9	yslo	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown	20 0000	304	_ O.IO. (O)	JOUNY)						
Q.	£ 25 €		Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	inderlying	cause give	n in Part I		23e. Did	tobacco use	contribute to	the cause of death?
rds,	n sign	d by									1 🕏	Yes 2□N	lo 3□Pr	robably 4 🗀 Unknown
of Vital Record	s been si should	Completed									24a. Wa		4b. Were au	utopsy findings available
æ	The lav	E									per	opsy formed? 2000	death?	completion of cause of : 2□ No
<u>ta</u>		0	25. Was case referred to medical						26. Place	of Deat	h (Check only			
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	ding Ph h. After th funeral		27. Mann f Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	ury ay Year)	28b. Time o Injury	of	28c. Injury Work	at c?		28d. Describe	how injury o	ccurred	
Sio	Attanding r death. ector: After by the fune	Satio	2 Accident investigation				М	10	Yes 2 🗌	No				
Division	of or Attand after death Director: d in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	286. Place of II	njury - At h atc. <i>(Speci</i>	iome, farm, st fy)	reet, facto	y, office				(Street and N own, State)	lumber or Ru	ural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in the Funerel or with the filled in the fill		no Cartific Attorney	voicies: T- #- t	t of marile	auladas de :	h =	l at the t	- data	od ele	and due to the	2 021/22/2	d mass==	n stated
	Hos 24 ho Fun	Medical	29a. Certifier 1 Certifying Ph (Check pnly 2 Medical Exam	ysician: To the bes niner: On the basis and manners	of examina	ation and/or in	n occurred vestigation	n, in my of	pinion, dea	ith occur	red at the time	, date and pla	ace, and due	e to the cause(s)
	To the within 2 To the complet	₩ W	29b. Signatule and title of certifier		_		29	c. License	number			29d. Date s	igned (Mont	h, Day, Year)
	⊢ s ⊢ ō		> V		h. L) .		D 4	453	90		hard	1218	- 2008
			30. Name and Address of person who	completed cause of	death (Ite	m,23a) (Type,	Print)			11		ο , Δ.	^	- O Bloud
			shyp Min (h.	0.)602	SON	oth At	WOO	dk	wad	# 2	200,2	Sel H	17	n. 2008 n. 2014
(A)	Sta		31. Date illed (Month, Day, Year)	32. Regis	trar's Sign	ature								
1	Regist	ar	APR 0 8 2008	The office		1								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21- StateAmend 29c per phys, DOR, 3/25/08 Certificate of Death

Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1314 PM Evere JOHN ack Son March 2008 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital at Easton Easton
If Under 1 Year | If Under 2 Talbot Memorical 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Hours Min Months Days Director Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Items 23a or 28a-f show at 1 Yes 2 No injury or other traumatic event, the Medical Examiner must be notified Director death with the 10g. Citizen of What Country? 10e. Street and Number 2. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 3 Wo Yes, Give Year or Dates: Village Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 'natural", or Specify þ 3 ☐ Widowed 4 ☐ Divorced BIOCK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatis." Elementary/Secondary (0-12) College (1-4or 5+) State Engineer State

18. Mother's Name (First, Middle, Maiden Surname) tationary Maryland 17. Father's Name (First, Middle, Last) Be Delores Jackson 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cambridge MD: 2/6/13 222-Media Ave, Apt. 103-C Delores Jackson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/29/08 Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 22. Name and Address of Facility MD. 21613 Immediate Cause (Final disease or condition resulting in death) Physician Evre slay welly direal yeard /Medical Due to (or as a consequence of): Examiner Hyperten ulasi if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed varcular LOVS empheral burial-trar Due to (or as a consequence of) or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46020 21/03. 084620 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed I. Ali, M.D. 506 Idlewild Avenue Easton, Md. 21601

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month,

Certificate of Death

		1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day	Vaas	3. Time of Death
Physicia /Medic		Alva Everette Jones				Month March	21	2008	8:00 P M
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death			County of Death	
		3122 Jenkins Lane		Bryans	Road			Charles	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	V Year)	Cou	place (State or Foreign ntry)
Director		279-03-2829 94	Yrs.			anuary	6,19	14 Ohio	
pun w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Lo	ocation					10d. Inside City Limits
aryla shov	7								1 ☐ Yes ▼XINo
he M 28a-f otifie	Director	Maryland Charles Brya 10e. Street and Number	ans	Road 10f, Zip Code			10a Citize	en of What Cou	
with 1	Ö			,					indy:
eath is 23 must	Funeral	3122 Jenkins Lane 11. Marital Status 12. Was Decedent Ever in U.S.	13	Was Decedent of H		acify Ves or No.	U.S.	A. Race - Ameri	can Indian.
iter d	Ę	1 Never Married 2 Married Armed Forces?	10.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White	
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes XXXVo	Specify:		5	Specify: Whi	te
2 hou atura cal E	ted		a. Dece	dent's Usual Occup	ation			d of Business/Ir	
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d wit	Completed		Engi	neer Tecl	1.		Or	dnance	
al Hy othe	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden S	Surname)	
Ment Ment arked arked	To	Everette W. Jones			Daisy	Winter	r		
2 should be and Mental Is marked c				ng Address (Street					p Code)
and and and and and and and and and and					34 ,, Ind				
of Heritan		20a. Method of Disposition XXXBurial 2 □ Cremation 3 □ Removal from State	of Dispo <i>ery, cre</i>	osition (Name of matory or other plac	ce)	Date	20c. Loc	ation - City or T	own, State
Pages ment of I ant: If ite ury or o		4 Denation 5 Other (Specify) St. Ch	nar1	es Cemete	ery 3/28			n Head,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	:	21. Signatule of Funeral Service Cipenseel	-)	2. Name and Addre					a,Md.20646
8058		Garyton C. Echols ; Jr.		ehart-Ech					
1000		23a. Part1. Enter the disease, or complications that coursed the death. Do shock, or heart failure. List only one cause on each line.	not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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/Medical Examiner		resulting in death) Due to (or as a consequence	of):	4	/				
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eath certificate be executed attending physician and for use as the burial-transit	cian/Medical	σ							
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To the Hospital or Attending Physician: The law requires that the de within 24 hours a 'er death, To the Funeral Director: After this certificate has been signed by the scompletely filled in by the funeral director, page 2 should be detached to	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge (Check only one) 1 Medical Examiner: On the basis of examination a and manner stated.							
o the ithin 2	Mec	29h Signature and title of cartifier		29c. Licens	se number	~ .	29d. Date	signed (Month	, Day, Year)
⊬≯Fŏ		Descripted for	40	DO	0 6 8 3	10	M	uh2	-7 2008
		30. Name and address of person who completed cause of death (Item 23a)	(Type	Print)					(
BBIOH		Dr. Paul Pritchett ,MD ,P.O. Bo			a Plata,	Marylan	d 206	546	
Sta	te	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature		_					
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			Pleas	e Type or Pri State of Ma	nt In Black I aryland / De _l				-	_	ible.	1100
					C	ertificate	e of	Death		Reg. No.	UU	1130
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	\$ 2 F	Sire	10e. Street end Number			10f. Zip (Code			10g. Citizen of	What Cour	itry?
	23a	a	204 Charles S	t.		19	9963	3		US	SA	
	dea F E	Je .	11. Marital Status	12. Was Decedent	Ever in U,S. 13	. Was Decede	ent of I	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N	o- 14. Ra	ce - Americ	
Maryland 21215-0020	hours after ural', or ite	by Fu	1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? I	No	1 Tes, speci			Hiçan, etc.)	Specif	ck, White, y: Whj	
ŏ	2 hot	8	15. Decedent's	Education	16a. Dec	edent's Usual	Occur	pation		16b. Kind of B	usiness/Inc	dustry
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an	wid be Mental arked o	Be	Linford T.	Jerread								
2		ပို						Gladys A				
Za	l 2 sh ls m rsum		19a. Informant's Name/Relationship	/				and Number or Ru		•	, State, Zip	Code)
	s 1 and f Health fram 27 other t		Gladys Jerread	- MOTHER/				l., Milfor				
0	ges 1 if of H if ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	TO Removal from State	20b. Place of Disp cemetery, cr	position (Nami ematory or oth	e of her ple	ce)	Date	20c. Location	- City or To	wn, State
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Baltimore,	Department Mportant: any injury		21. Signature of Funeral Service Lic	ensee		22. Name and				ort Fune		
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	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	edicai	Check only 2 Medical Exa	hysician: To the best o	f my knowledge, dea examination and/or i	th occurred at	the tin	ne, date and place, pinion, death occur	end due to the	cause(s) and ma	anner as st	ated. the cause(s)
	the f	8	one)	end manner ste	led.							
	Vit To To	Σ	29b. Signature and title of certifier			29c.	Licens	e number		29d. Date signe	d (Month, I	Day, Year)

Registrar DHMH 16 Rev 6/95

State

ORIGINAL

32 Registrer's Signeture

APR 0 8 2008

29d. Date signed (Month, Day, Year) 3-27-2008 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

29c. License number

D 25 391

Baltimose MD 21239.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕕 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death THOMAS **JONES** 3:55 P M JANUARY 17, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE MILLENNIUM OF FORESTVILLE FORESTVILLE PRINCE GEORGE'S 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 🕅 M 2 🗆 F 579-64-0468 NOV. WASH., 61 5, 1946 D.C. Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No D.C. WASHINGTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1440 N. ST., N.W. #301 20005 UNITED STATES Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th CONTRACTOR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MANSFORD JONES LILLIAN WINKEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELLY JONES/SISTER 3613 GALLATIN ST., HYATTSVILLE, MD. 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation GLENWOOD CEMETERY 2/4/08 WASHINGTON, D.C. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service victors 22. Name and Address of Facility CAPITOL MORTUARY INC. 1425 MARYLAND AVE., N.E. WASH., D.C. 20002 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ESOPUAGEAL CANCER Due to (or as a consequence of)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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Examir Physician/Medical Completed by Be Certification: To in 24 hours the Funeral Dire

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Unverrying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or as a consect d.					
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet. 4 □ Pregnant at time of 6 9 □ Unknown	al death 3 ⊟Ectopi	cpregnancy (specify)		23d. Date of de Month	elivery D <i>a</i> y Year
ted by Pt	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlyin	g cause given in Part I.		use contribute t	to the cause of death? Probably 4 \textcal{\textcal{X}} Unknown
Completed					24a. Was an autopsy performed? 1□ Yes 2M	prior to death?	utopsy findings available completion of cause of s 2 🗓 No
Be	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)		
일	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3□	DOA Other: 4 X Nursing	Home 5 ☐ Residence	6 □Other (Spe	ecify)
	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact fy)	tory, office	28f. Location (Street: City or Town, Sta	and Number or R ite)	Bural Route Number,
Medical (29a. Certifier (Check only one) 1 Certifying Physics 2 Medical Example 1	ysician: To the best of my know niner: On the basis of examina- and manner stated.	owledge, death occurration and/or investigat	red at the time, date and plaction, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner a and place, and du	as stated. le to the cause(s)
ž	29b. Signature and title of certifier	· · · · · · · · · · · · · · · · · · ·		29c, License number	29d. F	ate signed (Mon	th Day Year)

State Registrar

31. Date filed (Month, Day, Year) APR 08 2008

1916DNKW0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D0055314

29d. Date signed (Month, Day, Year)

3/19/08

within 2 To the

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me NANCY DOLGOS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) CHESTER CEMETERY 3/28/08 21. Signature of Funeral Service Licenses us 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIO PULHONANY **Physician** /Medical Due to (or as a consequence of): Examiner Ancealie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Al celial tictary to BACCO ABUSE 25. Was case referred to medical examiner? OF Division or Vital Be 26. Place of Death (Check only one) 2 1 No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN C. ARRABACTA. M.D. mis 31. Date filed (Month, Day, Year) 32. Registra State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 22, 2008 12:23P M MARCH JOYCE MARY KRUMPET /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT 7224 ROCK HALL RD. ROCK HALL If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 XF Months Days 148-16-0070 83 10/16/1924 NY Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 ☐ No Director KENT MD ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7224 ROCK HALL RD. 21661 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify. Specify: WHITE ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES SARTELL LOLA TURNER ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8214 WHISPERING PINES LN. CHESTERTOWN, MD 21620 20c. Location - City or Town, State CHESTERTOWN, MD 22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 Approximate Interval Between Onset and Death Carcilloun with Liver Hutoslases 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 223 Hogh Stuet, CHerfertown, Wed 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 9:30 A M 30, 2008 Mar. Mary Jo Koepper /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 3135 White Hall Road White Hall | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) | Aug. | 24, 1 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 20 F Yrs. Maryland 220-50-2500 1960 Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ※ No Director White Hall MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 3135 White Hall 21161 Road Funerai deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) oe filed within 72 hours after do al Hygiene. I other then "naturel", or item 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture permit. Peges 1 and 2 should be filled w Department of Health and Mental Hygies Importent: If item 27 is marked other th any injury or other treumatic event, the 2006. Farmer 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Robert Cala Mary Joan Redel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3135 White Hall Rd., White Hall, MD 21161 Joseph H. Koepper, Jr./Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Bethel Presbyterian Cemetery Apr. 1 DBurial 2 Cremation 3 Removal from State White Hall, MD * 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Lig 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 19 S. Main St., Stewartstown, PA 17363 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical o (or as a consequence of): Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner inding physicien and use es the buriel-trensit The lew requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Cal Physician/Medi ettending for use es IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was lecedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cete has been signed by the case has should be deteched. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 20 No certificate 1 Yes 1 Yes Hospital or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 8 Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification Natural 5 Pending s efter death.
I Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours e To the Funerel I completely filled Medical 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check o one) and magner stated 29d. Date signed (Month, Day, Year) 29b. Signat ertifie use of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) APR 08

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State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be ex- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	sician/Medic	IF FEMALE: 23b. Was decedent	pregnant in th	ne	23c. If yes,	outcome	of pregna	ancy	etal deat			pregnan	~.		23d. Date of o		ay Year
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	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2	Medical Exa	miner:	On the basis	of examin	nation and	d/or investig	ation, in r	ny opinion	, death occ	curred at	the time, d	ate and	place, and du	e to the	e cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Helga Kozub /Medical larch 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Dec 29 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 86 Months Days Hours Min. 171-28-2699 Director Dec. 1921 Estonia Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at PA. Franklin Director Chambersburg 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2085 Wayne Rd. 17201 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ∏ Yes 2 ⊠ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No iene. than "natural", or i 1 ☐ Yes 2 ☒ No Specify. Specify: White <u>Ş</u> 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Food Service Work permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If tem 27 is marked other the any Injury or other trainmant. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augustus Janson Margaret Sonnenberg ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Mitten/Daughter 505 Fairhill Rd. Hatfield, PA. 19440 20b. Place of Disposition (Name of cemetary, crematory or other place)
Geisel Funeral Home
& Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4/1/08 Chambersburg, PA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, PA. 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine unat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 20 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perform 2☐No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No Certification: To 1 Hnpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)1

The law requires that the death certificate be executed Box 68760, Division or Vital Records, P.O. Hospital or Attending 24 hours after death Funeral Director: completely within 2

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State **APR 0 8**

29b. Signature and title of certifier

455 12 ha aistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

			Please Type or Pr	i nt in Black In faryland / Depa			-	_	
			1 - State Registrar		rtificate of L			leg. No.2	3 11392
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ogvio Clyde	LA	IYTUN		2. Date of Dea Month MARIM	th Day Year Zo Za	
	Examin		4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or			4c. County of De	ath
				ge (In yrs. last birthday)		If Under 24 Hrs.		l a Bi	rthplace (State or Foreign
	Funeral Director		198–34–6798 1 Mx 2 F Usual Residence of Decedent	60 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day March 16,	1948	PA
	yland how at		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	ne Mar 8a-f s ptiffied	ctor	PA Fulton	Warfordsb					1 □Yes 🔏 No
	with the	Funeral Director	10e. Street and Number 257 Hendershot Road		10f. Zip Code 17267			10g. Citizen of What C USA	Country?
	ms 23	nera	11 Marital Status 12. Was Deceden	t Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	Armed Forces 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ 1 ☐ Yes 6 ☑ Year or Dates	₹No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify: Wh	,
215-0036	hin 72 ho s. in "natur Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o)	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired,	ation Juring most of work)	ing	16b. Kind of Business	
7	ed with	Com	12	, 1	k Driver			Hauling/D	elivery
and	0 = 0 =	Be	17. Father's Name (<i>First, Middle, Last</i>) Howard Layton			18. Mother's Name Fosta Tr		Maiden Surname)	
يَّ	should nd Me mark mark	은	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street a			r, City or Town, State,	Zip Code)
Ĭ,	and 2 salth a n 27 is er trau		Carol E. Layton/Wife					g, PA 1726	
Baltimore, Maryland	t of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat	20b. Place of Dispo cemetery, cre	osition (Name of ematory or other place	e) [Date	20c. Location - City of	r Town, State
<u>=</u>	it. Pac rtmen rtant: njury		4 Donation 5 ☐ Other (Specify)	Amaranth	Brethren 2. Name and Addres	04/01	/2008 V	Warfordsbu Main Stre	rg, PA
ă	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evores.		21. Signature of Funeral Service Licensee					ancock,MD	
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only the cause on each						Approximate Interval Between
,	Physician	9 18	Immediate Cause (Final disease or condition	Tie Shock					Onset and Death
	/Medical Examiner			s a consequence of):	Dan 200				
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be in initiated events.	s a consequence of):	pseudoa	ocorys.~			
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	s a consequence of):					
9	e be es sician e buria	ਰ	d	o a concoquento oi).					
9	rtificate ng phy as the	Nedic							
C. BOX	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. When the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d	elivery Day Year
7.	s that t ned by e detac	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	ınderlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ecords,	en sig	ed b	Respiratory failure				1 □ Y	es 2XNo 3□F	Probably 4 ☐ Unknown
Hecc	The law rite has be	Completed	-				24a. Was a autops perform	sy prior to	
VItal	cian: ertifica ector, p	BeC	25. Was case referred to medical examiner?		T	26. Place of Death			
5	Physical this of rall directions of the control of	ို	1 ☐ Yes 2 No Hospital: 1 Inpar 27. Manner of Death 28a. Date of In			4 Li Nursing Ho		ence 6 Other (Sp	ecify)
	th. : After	tion	1 Natural 5 Pending (Month, E		Work	es 2 □No	26d. Describe no	ow injury occurred	
DIVISION	after dea after dea I Director d in by the	Certification:	3 Suicide 6 Could not be 28e. Place of in	njury - At home, farm, sti etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
	ne Hospita 1 24 hours ne Funera eletely filler	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besi and manner sand manne	of examination and/or in	th occurred at the tim	ne, date and place, pinion, death occur	and due to the cred at the time, c	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	To the within to the company of the	Me	29b. Signature and title of certifier T.M. autitibe , 50		29c. License	number		19d. Date signed (Mor	
			30. Name and address of person who completed cause of	death (Item 23a) (Type,					
	Sta	te	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	Page 1	S.C. WILL			
DIII	Registr		APR 0 8 2008	A Aporta	9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 11393 State of Maryland / Department of Health and Mental Hygiene Lizzie Lee Leach Certificate of Death 1- For State Rea, No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) March 24, 2008 Physician/ 1745 hrs Examiner Lee Leach Lizzie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Days Hours DC 1952 Washington, Sept 4, Director 1 M 2 XF 55 579-72-8734 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No District of Columbia Washington notified at once 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20019 5337 Clay Terrace, NE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11, Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 XNever Married 2 Married 2 X No. Yes Specify: Yes 2 X No specify: Black Yes, Give Year Divorced 3 Widowed "natural" 16b. Kind of Business/Industry ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical R Baltimore, MD 21215-0036 Government Reproduction Clerk 12 years 8. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arzenia Robinson <u>Joseph Leach</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5337 Clay Terrace, NE Washington, DC 20019 Sharon Lilly-Joyner / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State April 5, 2008 Washington, DC enwood Cemetery Donation 5 Other Specify 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licenses Benning Road, NE Washington, DC Approximate Interval 23a. Parly. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Subarachnoid Hemorrhage due to ruptured Berry Aneurysm in Between Onset and ysician Death **ledical** a in association with Acute Cocaine Intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED23a,27,28a-f per ME g878 4/10/08 amh X UNPENDED red by the attending physician detached for use as the burial 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Year Day 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 V Unknown 2 24b. Were autopsy findings available Completed Division of Vital Records, 24a, Was an has been s prior to completion of cause of autopsy performed? death? ✓ Yes 2 No ✓ Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be Other₄ Nursing Home 5 Residence 6 Other examiner? DOA Hospital: 1 Inpatient 2 ✔ ER/Outpatient this 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After Certification: 1 Yes 2 X No hours after death.
uneral Director: A
ly filled in by the fu Natural 5 Pending Fnd 3/24/08 unk Fnd 2:32a Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be or Town, State) 1004 48th St. NE, Washington, DC 3 Suicide (Specify) House Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 25, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State

Registrar

Ana Rubio MD. 31. Date filed (Month, Day, Year,

2008

Assistant Medical Examiner

32. Registrar's Signatur

111 Penn Street, Baltimore, MD 21201

OCME

08-02559 Paul Andrew L	ouvie	Please Type or Print in Black Indelible Ink ere State of Maryland / Department of F		lvaiene	
		1- For State Certificate of D	Death	Reg. No. 200	8 139
Physic Medical Exan		r Paul Andrew Lou	viere	2. Date of Death Month Day Year March 31, 2008	3. Time of Death 1945 hrs
16.			City, Town, or Location of Deatl Montgomery Village	4c. County of Death Montgomery	
Funera Directo			If Under 1 Year If Under 24Hrs Months Days Hours Mir		thplace (State or on Washington, untry)
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Properate: If team 27 is marked of other than "matural", or items 23a or 28a-f show initing or additional and an orea.	Director	Maryland Montgomery Montgomery Vi 10e. Street and Number 19315 Club House Road #301	111age Of. Zip Code 20886	10g. Citizen of What Cou	1 Yes 2 XX No
ath with the liens 23a of the notifi	Funeral D		Decedent of Hispanic Origin? (S specify Cuban, Mexican, Puerto	Specify Yes or No- 14. Race - Amer	ican Indian, Black,
ural", or	by Fu	3 Vidowed 4Divorced in res, Give rear or Dates:	es 2XX No specify: Usual Occupation (Give kind of	Specify.	ite
036 thin 72 hou ne. r than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) School T	of working life. DO NOT use ref		
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. In a 72 is marked other than mumaric event the Medica	Be Cor	, Uris Frank Louviere	Mary	e (First, Middle, Maiden Surname) Louise McCallum	
MD 21 d 2 should lth and Me n 27 is ma	2	Regina L. Blanchette / Sister 4054 Wa	shington Road Murr	Rural Route Number, City or Town, State Caysville, West Virginia	
Baltimore, permit. Pages 1 an Department of Heal important: If iten		20a. Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition crematory or other Mt. Olivet Ce	place)	Date 20c. Location - City or 05/2008 Washington.	
Baltir permit. I Departmo		21. Sign of e of Funeral Service Licensee 22. Nam	ne and Address of Facility	George P. Kalas Funeral on Hill, Maryland 207	. Home P.A.
Physiciai /Medica		23.7. First. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a Caroline Arthurthur.)	mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
kamine		or condition resulting in death) Due to (or as a consequence of): b. Due to Cardi mealy			
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_ 0 .9.5	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	<u> </u>
OX 68760, sath certificate be attending physici for use as the buri	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal 4 Pregnant at time of death 5 Other	death 3 Ectopic pregn		Day Year
P.O. B s that the d gned by the	by Phy		erlying cause given in Part I.	23e. Did tobacco use contribute to	
Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be execut as after death. The Director: After this certificate has been signed by the attending physician and fine the fineral director, new? 3 should be deached for use as the burial. Trail	Completed				utopsy findings available completion of cause of
11. T	Ü	25. Was case referred to medical	26.Place of Death (Check		2 110
Vita hysicia this ce	0 0	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursi	ng Home 5 Residence 6 ✔ Othe	er: Scene
ion of tending Pleath.	ation: T	27. Manner of Death 1 X Natural 5 Pending Pending Pending	ry 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred	
Division of Vital Rector the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate!	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, (Specify)	factory, office building, etc.	28f. Location (Street and Number or Re or Town, State)	ural Route Number, City
To the Hosp within 24 ho To the Func	Medical C		d at the time, date and place, an i, in my opinion, death occurred	d due to the cause(s) and manner as stal at the time, date and place, and due to the	ted. ne cause(s)
F 3 F 8	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	onth, Day, Year)

State Registrar O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 1, 2008

David Fowler M.D.

31. Date filed (Month, Day, Year) APR 0 8 2008

30. Name and address of person who completed cause of death (Item 23a)

Chief Medical Examiner

Registrar's Signature

			1 - State Registrar	State of Mary	•	artment of F rtificate of			giene Reg. No. 200	18 1139
Physician			1. Decedent's Name (First, Middle, Las	st) NICHOLAS	ICHOLAS MAURO			2. Date of Death Month Day MARCH 25, 2008 2. Time of Death 2: 08P		
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, given FREDERICK MEMOR. 5. Social Security Number 115-14-6667	IAL HOSPITA	yrs. last birthday)	4b. City, Town, o FREDER If Under 1 Year Months Days	r Location of Death CCK If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Feb 20,	4c. County of D FREDERI	
; ivial ylalid 21213-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 71's marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Ď	Usual Residence of Decedent 10a. State 10b. County Maryland Frederic		c. City, Town or Lo					10d. Inside City Limits 1 ∰Yes 2 □ No
		Funeral Director	10e. Street and Number 814 Shawnee Drive			10f. Zip Code 2170			10g. Citizen of What	
		by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 2XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	. 14. Race - A Black, W Specify:	merican Indian, /hite, etc. white
	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's Et (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give		eation during most of work d) ter/superv		16b. Kind of Busine	
	uld be filed Mental Hygi arked other artic event, t	To Be Co	17. Father's Name (First, Middle, Last, John Mauro)				e (First, Middle,	Maiden Surname) known	
	and 2 sho lealth and I m 27 Is ma her trauma		19a. Informant's Name/Relationship (Michele Small -	daughter	288	Dill Aver	ue, Frede	erick, N		21701
	it. Pages 1 Intment of H Intant: If Ite Injury or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications) 21. Signature of Funeral Service Light	Removal from State (y)	Clustered	matory or other pla	3-29	0-2008		, Maryland
Da	Depa Impo any I		Marow (III. Enter the disease, or com	Mulle ()	ellue 1	621 Oposs	sumtown Pi	ike, Fre	Funeral Ho ederick, M ^{rrest,}	aryland 2170
,	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):							Onset and Death
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	icate be executed physician and the burial-transit	dical Exa	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	45N				yeur.
	he death certific the attending p ched for use as f	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify)	y		23d. Date of Month	delivery Day Year
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part 1.			e to the cause of death?
חביבו וג		Completed						24a. Was autoj perfo 1□ Yes	psy prior deat	e autopsy findings available to completion of cause of n? /es 2 \sumbox No
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatie	nt 3□ DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho		one) dence 6 □Other (8	Specify)
		Certification: T	27. Manner eath 1	e 290 Place of injuny	At home, farm, st	M 1□	y at k? Yes 2 □ No		Street and Number on wn, State)	Rural Route Number,
		Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the within To the Comple		29b. Signature and title of certifier A Raza	MA			66166		29d. Date signed (M	100
20	5+1		30. Name and address of person who Mudus ar Ra-	completed cause of death	(Item 23a) (Type,	Print) Sinde Mess	one llosge	re, f	rederide,	MD 21701
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2	6 2008 Registres	Signature	forthe	V			

DHMH 17 Rev 1/2001

			1 - State Registrar 1. Decedent's Name (First, Middle, L.			ertificate of		2. Date of D	Reg. No.	2000	3. Time of Death
	Physici	an	WILLIAM W.	MILES				Month	Day 21	Year 2008	3:00 A M
	/Medio		4a. Facility Name (If not institution, give street and number)			4b. City, Town, o	4b. City, Town, or Location of Death			County of Death	3:00 A
	Examili	lei	6001 Muncaster M	e Rocks	**			Montgomery			
e de la companya de l	Funeral Director	9	5. Social Security Number 6. 216-22-8671		(In yrs. last birthda 82 Yrs.		If Under 24 Hrs	8. Date of B (Month, D June	Day, Year)	9. Birthp	olace (State or Foreign ntry) yland
th with the Maryland	* A		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside City Limits
	f sho	ō	Md. Montgo	mery	Rockv	ille					1 XYes 2 □ No
	r 28a notif	Director	10e. Street and Number	_		10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
	23a o St be		503 Denham Road				20851		Uni	ited Sta	tes
9	ems (Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	B. Was Decedent of I	Hispanic Origin? (Span, Mexican, Pue	Specify Yes or N	10-	14. Race - Americ Black, White,	
yidilid < 1 < 1 3-0000 uld be filed within 72 hours after death with the Maryland	ral", or it	þ	1 ☐ Never Married 2 1 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	° wwii	1 ☐ Yes 2 🛣 No					hite
	e. an "natu Madical	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-4or 5-	(Gi	edent's Usual Occu ve kind of work done DO NOT use retire	pation during most of wo d)	orking	16b. Kii	nd of Business/Ind	dustry
	giene giene the	등	12	2		Accountant				comobile	Company
	tal Hy d oth event	Be	17. Father's Name (First, Middle, Las					me (First, Middl			
, pi	z should be med writing and Mental Hygiene. Is marked other than aumatic event, the M.	유	Moses Philman	Miles			Madal			Hawkins	
and 2 sh	perint. Teges I am La should be the winner it includes are beautiviting the way had perint. Teges I am Mantal Hygiene. Important: if I fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the IM dical Examiner must be notified at once.		19a. Informant's Name/Relationship Delores M. Miles	· **.	50:	iling Address <i>(Stree</i> i 3 Denham I	Road, Roo	ckville,	Md.	20851	,
2 2	or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	Removal from State	1	position (Name of rematory or other pla		Date		cation - City or To	
Б	tment tant: jury		4 ☐ Donation 5 ☐ Other (Spec	fy)	1	le Cemete		25/08		ckville,	Md.
imed	Depar Impor any ir		21. Signature of Funeral Service Lice Muruf M	Barber	,	22. Name and Addr Muriel P. O.	H. Barbe Box 5038	er Funer B, Layto	al Ho nsvil	ome Lle, Md.	20882
	hysician		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final			nter the mode of dy	ing, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	w	loidosis consequence of):						
E	xaminer		Cogneptially list conditions	h							
Ţ	2 %	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):						
CACITA	and I-trans	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of);						
ificate he executed	physician and s the burial-transit	edical E									
artifica	ന്ന		IF FEMALE:								
ath o	attending pl	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1☐Live birth 4☐Pregnant at	2 ☐ Fetal death 3	B⊟Ectopic pregnanc	ÿ		2	23d. Date of delive Month	ery Day Year
) of	y the	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	ille of death	□ Other (specify) _					
that	ned by deta		Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco u	se contribute to the	he cause of death?
To the Hospital or Attending Physician: The law requires that the death cert	n sign	ed by						1 🗆	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unkn		
	s bee	Completed						24a. Wa		24b. Were auto	ppsy findings available
	ate high	mo						per 1 Yes	opsy formed? 2. No	death?	mpletion of cause of 2 □ No
	ertifica ctor.	Be	25. Was case referred to medical examiner?					eath (Check only	_/		
	this co	2	1 ☐ Yes 2 1 No		nt 2 ER/Outpati	CIT OLI BOX		Home 5 ☐ Res	sidence 6	Other (Specif	y) Hospice
	After	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injury	Wo		28d. Describe	how injur	y occurred	
	death	icati	2 Accident investigation 3 Suicide 6 Could not l	M 1 Yes 2 No		n (Street and Number or Rural Route Number,					
	rs after al Director	Certification:	4 Homicide building, etc. (Specify)								
	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 27 Medical Examiner: On the bast of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Total	withii To ti	Me	29b. Signature and title of certifier 29c. License number D 0064615						29d. Date signed (Month, Day, Year) March 21, 2008		
lo	30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)								050		
U			Genevieve Wroble			iccard Dr	ive, #100	, Rockv	ıııe	, Ma. 20	ສວບ
	Sta Registr	8	3½ Date filed (Month, Day, Year) MAR		r's Signature	Aports.	,				
НМН	H 17 Rev 1/2	001	1100 111								* *

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

		Registrar	Ce	rtificate of Death	-1	Reg. No.	
Physic		1. Decedent's Name (First, Middle, Last) THOMAS (M12	LER SR		2. Date of Dea Month	Day Year	3. Time of Death
/Medi Examii		4a. Facility Name (If not institution, give street and n Manor Care Woodbridge		4b. City, Town, or Location of C	Death	4c. County of Death Baltimore	1 0 - 71
Funeral Director		5. Social Security Number 6. Sex 1. M 2. F	7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24	Hrs. 8. Date of Birth Min. Feb 3,		nplace (State or Foreig
Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. City, Town or L	ocation tt City			10d. Inside City Limit
with the 3s or 28e	i Director	10e. Street and Number 3300 N. Ridge Road		10f. Zip Code 21043		10g. Citizen of What Cor	untry?
is 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Memtal Hygiene. It then 21 is merked other then "natural", or Itams 23a or 28e-f show other traumatic event. It a Medical Estaminational be notified at	by Funerai	11. Marital Status 12. Was De Armed F 1 □ Never Married	2 🗆 No	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		, etc.
within 72 ho lene. r then "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College) (Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)		16b. Kind of Business/I	
iould be tiled will I Mental Hygien harkad other th hatic evant, the	To Be C	17. Father's Name (First, Middle, Last) George H. Miller		18. Mother's Lillie	Name (First, Middle, Mae Sheph	Maiden Sumame) nerd Miller	· · · · · · · · · · · · · · · · · · ·
1 and 2 sho Health and tam 27 is ma			aughter 1014	ng Address (Street and Number of Peed Lane	r Rural Route Numbe Ellicot	r, City or Town, State, Zi t City MI	21042
Page		20a. Method of Disposition 1 3 □ Removal from 4 □ Donation 5 □ Other (Specify)		esition (Name of matory or other place) emorial Gardens	Date 3/27/2008	20c. Location - City or T LaVale	own, State
permit. Pag Department Important: I any injury o		21. Signature of Funéral Service Licensee	rolly	Name and Address of Facility Scarpelli Funeral 108 Virginia Aver	Home, PA	land MD 21502	>
hysician /Medical Examiner			caused the death. Do not enleach line. PNEUM (or as a consequence of):	er the mode of dying, such as car	diac or respiratory an	rest,	Approximate Interval Between Onset and Death
attending physician and for use as the burial-transit	n/Medical Examiner	cause. Enter Underlying Cause (ciecase or in jury that initiated events c.	(or as a consequence of):				
rify social. The law requires that the beaut bettillicate be executed to this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliv	rery Day Year
been signed the should be det		Part II. Other significant conditions contributing to a ALZMEMMER'S	leath but not resulting in the u		23e. Did to 1 □ Y	bacco use contribute to les 2 ŪMo 3 ☐ Pro	
ate has be page 2 sho	Completed by	CURUNARY ARTERY	DISEASE		24a. Was a autops perfor	sy prior to co	opsy findings available ompletion of cause of
is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐	Inpatient 2 ☐ ER/Outpatien	0.1	Death (Check only or		
death. ctor: After this y the funeral o	P 4	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	of Injury th, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No		ence 6 Other (Speci ow injury occurred	<i>Ty)</i>
	Certific	4 Homicide build	of Injury - At home, farm, stri ing, etc. (Specify)		City or Town		
within 24 hours after To the Funeral Dirac completely filled in b	edical	29a. Certifier 1 Certifying Physician: To the Cone) 2 Medical Examiner: On the band and man	e best of my knowledge, death asis of examination and/or inv ner stated.	occurred at the time, date and playestigation, in my opinion, death o	ace, and due to the c ccurred at the time, d	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
(# E		29b. Signature and title of certifier		29c. License number	_ 2	9d. Date signed (Month,	Day, Year)

DHMH 17 Rev 1/2001

State Registrar

APR 0 8 2008

ORIGINAL

		,	. For	se Type or Prin State of Ma		Depa	artment of H	dealth and		_	ble.	
7	Physici		1 - State Registrar 1. Decedent's Name (First, Middle Douglas Wil			Cei	rtificate of	Death	2. Date of Deat April 2,	eg. No. / th 2008	Year	3. Time of Death 9:45 AM
	/Medio Examir		4a. Facility Name (If not institution Frederick Memo		1		4b. City, Town, o	or Location of Death	h	4c. County Fred	of Death	
23 T	Funeral Director		5. Social Security Number 214–28–0365		e (In yrs. last 76	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth Apr. 2,	Year 932	9. Birthpi Mary	lace (State or Foreign
	Maryland a-f show ified at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frede		10c. City, To						10	0d. Inside City Limits 1 □X es 2 □ No
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 1001 Young Pl	Lace			10f. Zip Code 21702		1	0g. Citizen of V		try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 □ Never Married 2 Marr 3 □ Widowed 4 □ Divorced	If Yes Give	Ever in U.S. No		Vas Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sean, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	Blad	ce-America ck, White, (White	etc.
Maryland 21215-0036	I within 72 ho piene. r than "natur t he Medical I	Completed by		t's Education st grade completed) College (1-4or 5		(Give life, l	dent's Usual Occup kind of work done DO NOT use retire COO Of P	during most of world)	rking	16b. Kind of B		
yland 2	ould be filed Mental Hyg harked other hatic event,	To Be C	17. Father's Name (<i>First, Middle</i> , Ernest Paul	Magaha, Sr.				Alice	me (First, Middle, F e Lilliar	n Wilso	n	
, Mar	and 2 sh ealth and n 27 is m		19a. Informant's Name/Relations Mrs. Joan S. M		1	1001	Young P1	ace, Fre	derick, M	1D 2170	2	
Baltimore,	Pages 1 nent of H ant: If iter ury or oth		20a. Method of Disposition 1 Burial 24 Cremation 4 Donation 5 Other (S		20b. Place ceme Smit	e of Dispo etery, crer chsbu	sition (Name of matory or other pla irg Crema	tory Apr	. 3, 2008	20c. Location - Smit	•	ewn, State Cg, MD
Balt	permit. Departr Importa any injl		21. Signature of Funeral Service		100255				ord PA Fureet, Fre			21701
V.	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause of each lin	ie.			ng, such as cardia		est,		Approximate Interval Between Onset and Death
3760,	/Medical Examiner uysician and he pnuial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a contract of the contract of	a consequen	ce of):						
P.O. Box 6876	Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗆 Fetal de	ath 3□	Ectopic pregnanc	у			ate of delive	ery Day Year
	w requires that been signed by should be deta		Part II. Other significant condition	. //	ut not resultin	g in the u		ven in Part I.				ne cause of death? eably 4 🗹 Únknown
al Reco	n: The law re ficate has bee r, page 2 sho	Completed by								med? 2 Mo	prior to cor death?	psy findings available mpletion of cause of 2 No
ž <	hysicial this certii tl directo	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Lampatie			IL SEL DOX	ner: 4 Nursing H	ath <i>(Check only on</i> Home 5☐ Reside		ner (<i>Specif</i>)	y)
Division or Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1 12 Natural 2 Accident 3 Suicide 4 Homicide 2 Could determ	gation not be 280 Place of init	y Year) ury - At home	b. Time of Injury , farm, str	Wo	ryat rk?]Yes 2 □ No	28d. Describe ho	reet and Numb		d Route Number,
ō	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ceri	(Check only 2 Medical	ng Physician: To the best of Examiner: On the basis of	of my knowle				e, and due to the c	ause(s) and m		
	To the I within 2. To the I complet	Med	29b. Signature and title of certifie	and manner sta			29c. Licens	se number 1936	2	9d. Date signe		
•			30. Name and address of person Andrew 0. Do	who completed cause of do	eath (Item 23	a) (Type, C Tho	Print) omas John	son Driv	e, Freder	cick, M	 D 217	· '02
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 8	32 Registra	ar's Signature							
DHI	MH 17 Rev 1/2		MINUO	2000	J AF	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Ronald Clayton Ovens 1007 M March 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ORCHESTER GENERAL AMBRIDGE HOSPITAL on choster If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Director 113-34-7482 64 Oct. 21, 1943 New York Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Dorchester East New Market Director 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 5516 Cedar Grove Road 21631 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 1967-71 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+ school administrator education Department of Health and Mental Hygic Important: If item 27 is marked other any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clayton Ovens Margaret Hoagland Pages 1 and 2 should the Pages 1 and 2 should the Page 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Ovens wife 5516 Cedar Grove Rd., East New Market, MD 21631 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Unity Washington Cem. 3/28/08 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCP515 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 65 treptococcus neumonia Sequentially list conditions distance a consequence offi-Examiner If any, leading to him edicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed pacterem 1 a Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 25. Was case referred to medical examiner? director 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After **Hospital or Attending** 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 24 hours after death Puneral Director; 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/23/08 4005993

State

DHMH 17 Rev 1/2001

Registrar

Cambridg MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008^{32. Reg}

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day **Physician** Zoo Year 2:32 LARRY OLIPHANT 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PARK MONG GOMER? HOSPITAL MAINTING BUCHAIN Micamy If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)

June 20,1949 Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ MM 2 □ F Director 58 578-66-0178 Wash, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f show the Medical Exeminar must be notified at 1 ☑ Yes 2 ☐ No Director MD Montgomery College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4711 Berwyn House Rd, #301 20740 U.S.A. death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1XYes 2 No If Yes, Give Year or Dates: 68-87 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tiled within 72 t Department of Health and Mental Hygiene. Important: If item 27 ts marked other than "natu any injury or other traumatic event. In a Madical Elementary/Secondary (0-12) College (1-4or 5+) MNCPPC Park Police 12tn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter A. Oliphant Mamie L. Johnston 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela D. Oliphant (Wife) 7821 Muirkirk Rd, Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State th Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem 4/9/08 Ft. Myer, VA ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europal Service License 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCUD Pnysician /Medical Due to (or as a consequence of) **Examiner** PERKARIMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner sician and burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown signed by tid be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 🗆 No 1 Yes 2 1 Yes or Attending Physician: 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 10 1 Inpatient 2 ER/Outpatient 3 DQA this 28a. Date of Injury (Month, Day Year) funeral 27. Mann of Death 28c. Injury at Work? Certification: 28h Time of 28d. Describe how injury occurred After 1 atural 5 Pending after death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a

To the Funeral I
completely filled To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 03-20-2008 address of person who completed cause of death (Item 23a) (Type, Print) J. Amis 7600 1) whaum NO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 25 2008 Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Emily Jane Orrison 31**,** 2008 March 12:50 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care and Rehabilitation Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) February 7, 1920 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F 220-05-6048 88 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State 10h. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🙀 No Frederick Middletown Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or any or other traumatic event, the Medical Examiner must be r 21768 United States 2803 Grandview Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel B. Webb Clinton Allen Kreimer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2803 Grandview Drive, Middletown, Maryland 21768 R. Donald Orrison / Son Baltimore, 20b. Place of Disposition (Name of semetary, crematory or other place)
RESTHAVEN April 3, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department or Important: If any injury or Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Licensee 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** unann /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a punsiculinge of Physician/Medical Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for P.O. 9 Unknown The law requires that signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 2No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has be irector, page 2 s autopsy performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 7. Manner of Peal 1 Natural 2 ☐ Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of ause of death (Item 23a) (Type, Fint 30. Name and address of person who completed 300 West Ninth Street, Freederick, Maryland 21701 Robert L. Kaufmann M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 🗎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician **JOSE PH** JOHN POLVINALE JR. March 22 2008 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6409 STREAM VALLEY WAY GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Oct. 3 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Year) 1943 1**X** M 2□ F Min 579-54-1098 64 Yrs. Director Washington, D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If item 27 ie marked other than "natural", or items 23s or 28s-/ show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits traumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Directo Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6409 Stream Valley Way 20882 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Manager Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph John Polvinale Wi.1ma Knighten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i tother tri Sherry Lynn Polvinale / Wife 6409 Stream Valley Way, Gaithersburg, Md. 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 3/27/08 Resthaven Cemetery Frederick, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Muriel H. Barber Funeral Home Box 5038, Laytonsville, 20882 P. O. Md. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part1, Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Years Metastatic Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to the cause of the caus Examiner Que to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last physician and Due to (or as a consequence of): Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? this certificate 1 Yes 2 No After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 임 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1. Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the it 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lu Medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and marring stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) March 24, 2008

Box 68760

P.O.

Division of Vital Records,

State Registrar

Frederick P. Smith, M.D. 32. Registrats Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

5454 Wisconsin Ave., #1300, Chevy Chase, Md. 20815

D 33293

State of Maryland / Department of Health and Mental Hygiene

2008 11406

or Lugoro			- For State Critical For State Certificate of Death	Reg. No	O	
Physic		1/	1. Decedent's Name (First, Middle,Last)	Date of Death Month Day	Year	3. Time of Death 0359 hrs
* I Exar	nin		ALLEN EUGENE PRATHER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	March 20, 200	18 4c. County of Death	
		4	4a. Facility Name (if not institution, give street and number) N. B. Muncaster Mill Rd./ N. of Avory Rd. 4b. City, Town, or Location of Death Rockville		Montgomery	
Funera	al		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth(MI	M/DD/YYYY) 9. Birth	place (State or
Directo			217-25-9876 X M 2 F 18 Yrs. Months Days Hours Min	Sept. 2	25,1989°oui	ntry) MD
		Ŀ	Usual Residence of Decedent			10d. Inside City Limits
w any			10a. State 10b. County 10c. City, Town or Location MD Montgomery Germantown			1 X Yes 2 No
land f sho	once.	ģ		10g C	itizen of What Count	
e Mary	ied at	Director	10e. Street and Number 20420 Apple Haevest Cir, #K 20876	,	U.S.A.	
hours after death with the Maryland	notif		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		14. Race - Americ	an Indian, Black,
leath v	nst be	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.	11-
after c	ner n	ğ F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify:	La	орсону.	lack
hours	Exam		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	work done 160 tired)	o, Kind of Business/Ir	ladustry
36 hin 72 than "	dical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Preloader		U.P.S	•
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	he Me	하	17. Father's Name (First, Middle, Last) 18.Mother's Name	e (First, Middle, Maid	en Surname)	
De fill ontal F	vent, t	Be	Allen E. Demar Chev	on L. Pr	cather	Zin Codo)
D 2, should and Me	atic e	유	19a. Informant's Name/Relationship (Type, Print) Chevon L. Prather (Mother) 19b. Mailing Address (Street and Number or 20420 Apple Har	TACE + Cir	CO.	MD 20876
and 2 sho lealth and tem 27 is	traum		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		c. Location - City or	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural",	other		1 X Burial 2 Cremation 3 Removal from State crematory or other place) Brooke Grove Cem 3/	^{'28} /08 I	avtonsv	ille. MD
l ltin nit. Pa artme oortan	ry or	ŀ	21. Schature of Funeral Service Ligensee 22. Name and Address of Facility S.N.	OWDEN FU	NERAL HO	DME, P.A.
Dep Dep III	ij.	_	Thomas Mashingt	on St, Ro	ckville	MD 20850 Approximate Interval
hysicia ledic		1	23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arrest,	snock, or neart	Between Onset and Death
_xamin		I	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			200
			Sequentially list conditions, b.			
		iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
В	=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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60, ate be ex shysiciar	burial	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	,
6876 certificat nding ph			23b. Was decedent pregnant in the past 12 months?	nancy	Month [Day Year
Box 6 e death cer the attendi	for use as the	Physician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown			
O. B. the de	ह	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
, P.O res that t	be deta	by		1 Yes	2 No 3 Prol	pably 4 Unknown
Records, The law requir	hould	Completed		24a. Was an autopsy	prior to	itopsy findings available it completion of cause of
eco ne law te has		g		performe 1 ✓ Yes 2		es 2 No
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of Vital ng Physician: After this certi	ig	P P	1 Yes 2 No	sing Home 5 Re	sidence 6 Othe	r: Scene
n of ding Pl	fune	E	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (North, Daylear) Mar 20, 2008 28b. Time of Injury 28c. Injury at Work? 1 346 hrs 1 Yes 2 ✔ No	Driver auto co	llision, patly eje	cted and pinned
Division tal or Attendiins after death.	by the	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, City
Div	filled in	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	or Town, Stat N.B. Muncaster	e) Mill Rd. / N. of Av	ory R, Rockville, Md.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I	etely fi		29a. Certifier 1 Continue Physician: To the best of my knowledge death occurred at the time, date and place, a	and due to the cause(s	s) and manner as sta	ted.
To the To the To the	completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated. 29b. Signature and title of certifier.		29d. Date signed (Mo	
5		Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		March 20, 2008	, = 2,, , 50,,
3			30. Name and address of person who completed cause of death (Item 23a)			
			Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
		ate	31. Date filed (Month, Day, Year) 2008 32 Registrar's Signature			
Red	aisí	trar	MIHIC & O COULD IN THE PROPERTY OF THE PROPERT			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 17, Martha Louise Paige 2008 9:15 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Nursing Home Clinton \mathbf{FG} 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1□ M 2₩ F 579-34-3508 Director 78 Yrs 03/05/1930 Washington, D.C. Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, I'm Medical Examinat must be invitibled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD \mathbf{RG} Fairmont Heights Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5903 Lee Place 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Food Services D.C. Public School 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Howard Claggette Annie Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen V. Paige - Daughter 5903 Lee Place; Fairmont Heights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Ft. Lincoln Cemetery 4 □ Donation 5 □ Other (Specify) 03/24/2008 Brentwood, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service License 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part Anter the disease, or cor ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest because on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) orgestive Heart Vaclure **Physician** /Medical Due to (or as a consequence of) Examiner aid is my opathi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner disease the attending physician and ched for use as the burial-transit death certificate be executed Coronary Due to (or as a consequence of): P.O. Box 68760 an/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide in by t Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature apolitile of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 51520 March 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Avenue, SE #310; Washington, D.C. 20032 Bahram Pishdad, M.D. 31. Date filed (Month, Day, Year) MAR 2 4 2008 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 41/M 2008 March DINSON 100 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery HOSD, to General M ON190Mer Year (f Under 24 Hrs. 8. Date of Birth (Month, Pay, Oct. 1, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 5. Social Security Number Pennsylvania Days Months 1 M 2 XF 85 172-16-0274 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 √ Yes 2 No Montgomery Silver Spring Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 20906 15301 Pine Orchard Drive, # 2H 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Black, White, etc. White 1 XNever Married 2 Married 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Community Theatre Performer 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Lurie Louis Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11607 D K Ranch Road, Austin, Texas Heidi L. Shalev - Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Columbia Mem. Park Date 20a. Method of Disposition
1 🔀 Burial 2 □ Cremation 3 □ Removal from State Columbia, Maryland 3/21/2008 `4 □Donation 5 □Other (Specify) Danzansky-Goldberg Memorial Chapels, Inc. +1170 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Licensee 20852 23a. Part 1. Enter the disease, or complications that caused the sath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death teno, HOUTE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No 2 🗌 No 1 Yes 26. Place of Death (Check only one) Hospital: 1 [Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of

Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and as the burial-transit Division of Vital Records, P.O. Box 68760 ate has been signed by the atterpage 2 should be detached for i the funeral director.

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

Directo

Completed by Funeral

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural," or Itams 23a or 28a-f ahow important: if Item 27 is marked other than "natural Examination or other traumatic event, the Medical Examination must be notified at once.

Physician

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine Completed by Physician/Medical

/Medical filled in by

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Medical Certification: To Be 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of

25 2008

Montgomery General Hospital 32 Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

18/01 Prince Phillip Dr Olney MD 20832

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OSALIE MARCH 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac Manor Care Potomac If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 □ M 2 🕱 F 16, 1916 Georgia Sept. Director 256-07-7015 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County r 28a-f show notified at 1 ☐Yes 2 No Silver Spring Montgomery Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20902 United States than "natural", or items 23a or the Medical Examiner must be r 11708 Auth Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 □ Never Married 2 □ Married white 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: If Yes, Give Year or Dates: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Administrative Assistant the 12 other 18. Mother's Name (First, Middle, Maiden Surname) Hilda Levy 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be Gilbert Abelsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 11708 Auth Lane, Silver Spring, MD Merryl Shaffir, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐ Removal from State Atlanta, GA Arlington Memorial Park 03/25/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Cancer Physician 7Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-trans and Due to (or as a consequence of): P.O. Box 68760 physician certificate be Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Failure to Thrive Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an Advanced Age has autopsy performed? /es 2X No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral! 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 24, 2008 D 31319

State Registrar 31. Date filed (Month, Day, Year) 25 MAR 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () § Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day MARCH 18, 2008 **Physician** KITRINIA IRENE REDMOND 5:19 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6710 TROWBRIDGE PLACE FORT WASHINGTON PRINCE GEORGE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) OCT • 27 19 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔏 F Months Days Hours Min 230-64-0945 Director 61 1946 VIRGINIA Usual Residence of Decedent 10c. City. Town or Location 10a. State show 10h County 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f sh in]ury or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2X No MARYLAND PRINCE GEORGE FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ö 6710 TROWBRIDGE PLACE 20744-3267 U.S.A.Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental F Be LUTHER TRAWICK FLORA TAYLOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s.
Department of Health ar
Important: If Item 27 Is
any injury or other trau ROBERT REDMOND (HUSBAND) 6710 TROWBRIDGE PLACE FORT WASHINGTON, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State SHILOH BAPTIST CHURCH 03/22/2008 REEDVILLE, VIRGINIA □Donation 5 □ Other (Specify) ignature of Funeral Service Licensee 22. Name and Address of Facility BERRY O. WADDY 6784 MARY BALL ROAD LANCASTER, VIRGINIA 22503 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Caucer metastatu 010 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 214 No 1 Tes Other: 4 Nursing Home ٩ 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24/08 H 666665 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONA LESKUSKI, MD 9200 BASIL COURT SUITE 200 LARGO, MARYLAND 20774

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year MAR 2 4 2008

		-	For State	State of Ma	ryland	•	artmen tificat			/lental Hy			
97			Registrar 1. Decedent's Name (First, Middle, La			0, 0		2. Date of De	eath Day	O S Year	3. Time of Death		
	Physicia /Medic	_	William H. Spen							March	21, 2	800	4:20 A ^M
	Examin	er	4a. Facility Name (If not institution, giv 576 Frenchtown					^{Town, or L} kton	ocation of Death.			nty of Death	
12	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. las		If Under		If Under 24 Hrs. Hours Min.	8. Date of Bi	rth		lace (State or Foreign
	Director		219–18–0053 1 Usual Residence of Decedent	M 2□F	81	Yrs.		34,5		12/24/		M	
	yland at		10a. State 10b. County		10c. City, T		cation	_				1	0d. Inside City Limits
;	ne Mar 8a-f sl otified	Director	MD Cecil		E1.	kton	1.4.			Т	10 0"		1 ☐ Yes 2 ☑ No
:	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number 576 Frenchtown	Road			10f. Zip	921			USA	of What Cour	ury ?
	ems 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Deced	dent of His	panic Origin? (Sp , Mexican, Puerto	pecify Yes or No Rican, etc.)	0- 14.	Race - Americ	
36	rs after	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give 19 Year or Dates.	。 51 – 19		1 □ Yes		Specify:			ecify: Whí	
21215-0036	72 hour natural ical Ex	ted !	15. Decedent's E	ducation		16a. Deced	dent's Usua	al Occupat	tion wing most of wor	kina	16b. Kind o	f Business/In	dustry
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a	12 sh hand 7 is m fraum		19a. Informant's Name/Relationship (Dolores M. Sper				-	,	nd Number or Ru Rd., El				Code)
	es 1 and of Health fitem 27 rother tr		20a. Method of Disposition		20b. Plac	e of Disponetery, cren	sition (Nar	ne of	1	Date	20c. Locati	on - City or To	own, State
altimore,	Pages ment of I ant: If its jury or o		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		1	s Cen	etery	7	03/2	26/2008		ls, MD	
Balt	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Lice	Keoren		22	Strar 635 (d Address 10 & Churc	Feeley F hmans Ro	ramily E bad, Nev	Tuneral wark, E	Home E 197	02
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В	Director		578-54-1393]M 2⊠F	99	Yrs.	Months	Days	Hours	Min.	(Month, D. Aug. 7	ay, Year)	8 New	place (State or Foreign intry) York
	pu *		Usual Residence of Decedent 10a, State 10b, County		10c Cit	r, Town or Lo								
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	3a or		3000 North Ridge	Road				.043				-	S.A.	mu y :
	death	nera	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13. 1			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Amer	
9	after or the	by Funeral Directo	1 Never Married 2 Married	Armed Fo 1 ☐ Yes If Yes, Giv	2 🔀 No		⊺Yes,sp <i>ec</i> 1∐ Yes 2			, Puerto	Hican, etc.)		Black, White	,etc. ite
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/lar	Venta Wenta rrked	To E	Joel H. Drummon	nd					Laur	a l	Miller			
Maryland	2 sho and I		19a. Informant's Name/Relationship (T)	rpe, Print)									Town, State, Zi	
	and lealth m 27		Ofelia Ross/Guard	ian	les s					way	Dr., Co		ia, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from S	State	ace of Dispo emetery, cren				03/2ໍ້	5/		ation - City or T	
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1	To t To t	₹	29b. Signature and title of certifier	1. 1	11		29c.	License		·		29d. Date	signed (Month,	Day, Year)
,	1	-	30. Name and address of person who co	moleted cause	of death (Item	23a) (Tuno 5	Print\	リロ	819			6	1,010	4
-			TAINEEM LAKH	ATTI :	2835	SMIT		VE,	Sul	76	203,	13A	UD M	1) 21208
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1650

9. Birthplace (State or Foreign

10d, Inside City Limits

Approximate Interval Between Onset and Death

Day

2□ No

Year

1 Yes 2 No

MARYLAND

WHITE

Division or Vital Records. P.O. Box 68760. funeral director. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

1 Medical PKWX

			1 - For Stata Registrar	State of M	1 arylar		artment of rtificate of		and Mo		giene Reg. No. ()	3	
	Physici /Medic		1. Decedent's Name (First, Middle, Last Luther Swafford,							2. Date of Dea Month March	18 ^{pay} 200)gear	3. Time of Death 7:00P. M
	Examir		4a. Facility Name (If not institution, give St. Mary's Hospit		r)		4b. City, Town, Leonard	town			4c. County St. M.		S
o	Funeral Director		5. Social Security Number 6. Se 512-12-8725	X 7. A	ige (In yrs. 84	last birthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birtl (Month, Day AUg • 8	1923	9. Birthp Cour Kan	place (State or Foreign htry) S3S
	Maryland f show	tor	10a. State 10b. County Maryland Montgomer	y	1	ty, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2X No
	with the	i Director	10e. Street and Number 3144 Gracefield Ro	ad,#T13			10f. Zip Code 20904				10g. Citizen of V United		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event. If a Medical Exam her must be multilized and DES.	by Funeral	11. Marital Status 1 Never Married 2 Married X Widowed 4 Divorced	12. Was Deceden Armed Forces 1 XYes 2 If Yes, Give Year or Dates	:?] No		Was Decedent of f Yes, specify Cu		gin? (Spec), Puerto P	cify Yes or No- tican, etc.)	14. Rac Blac Specify	k, White,	ean Indian, etc. hite
21215-0036	l within 72 hor iene. r than "natur the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary 0-12)	cation		16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	e durina mos	t of workin	g	16b. Kind of Bu		•
Maryland 2	uld be fited Mental Hygia Irkad other Itlc event, I	To Be C	17. Father's Name (First, Middle, Last) E. Luther Swafford							(First, Middle, M. Lyal	Maiden Sumam	16)	,
, Mary	and 2 should saith and Men n 27 is marks nar traumatic		19a. Informant's Name/Relationship (T) Sarah I. Higgs, da			1	og Address (Stree Old Hor						code) e,Md.20659
Baltimore,	Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition 1		! 0	cemetery, cren	sition (Name of natory or other pla Veteran	s Cem.		5/2008	20c. Location - Chelten	-	own, State Maryland
l Balt	permit. Departi		21. Signature of Funeral Service Licens	newa	relit	2 De 44	Name and Addr Onald V. 400 Powd	ess of Facilit Borgw er Mil	erdt 1 Roa	Funera ad Belt	l Home, sville,	PA Mar	yland20705
B	Physician // Medical Examiner and physician supply sician and physician and supply sup	Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	ine. Phis a consequence of the c	Quence of):	shoc	K			rest,		Approximate Interval Between Onset and Death
68760,	ificate be g physicia as the bu	edical	C.	d.		110					: >>> >>>		
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pregnand Other (specify)	су	-		23d. Dat Mor	e of delive	ery Day Year
	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions con.			ulting in the ur		iven in Part I.				ribute to	ne cause of death?
Division of Vital Records,	: The law r cate has be page 2 sh	Completed	· CAD,	HTN						24a. Was a autop perfor 1 Yes	med3/	rior to co leath?	psy findings available mpletion of cause of 2 No
Z X	ysician is certif director	To Be	25. Was case referred to medical examiner?	lospital: 1 /Inpat	ient 2 🗆	ER/Outpatien	t 3 DOA			(Check only or e 5 ☐ Resid	ne) ence 6 □Oth	er (Specif	y)
sion o	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	Certification;	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury a <i>y Ye</i> ar)	28b. Time of Injury	28c. Inju Wo M 1	-	28		ow injury occurr		
<u>X</u>	To the Hospital or Att within 24 hours after do To the Funeral Diract completely filled in by t		3 ☐ Suicide 6 ☐ Could not be determined	building, e	tc. (Specit	y) 	eet, factory, office			City or Tow	n, State)		l Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edicai	29a. Certifier 1 Certifying Physical (Check only one) 2 ☐ Medical Exami	sician: To the bes ner: On the basis and manner s	of examina	wiedge, death ition and/or inv	occurred at the trestigation, in my	ime, date an opinion, deal	d place, ar th occurre	nd due to the o d at the time, o	cause(s) and ma date and place, a	nner as si and due to	tated. the cause(s)
}	To the comp	ž	29b. Signature and title of certifier	Lal	س			se number	113	2	3/19/0	(Month,	Day, Year)
			30. Name and address of person who co Sureshbhai H. Pate	ompleted cause of 1, M.D.	death (Iten	n 23a) (Type, I Point	Print) Lookout	Road	Leon	ardtown	n, Maryl	and	20650
14	Sta Registr		31. Date filed (Month, Day, Year)	<i>E7</i> .	trar's Signa	ature	radio D		-		40.000.00.100		

DHMH 17 Rev 1/2001

Lyther Swafford Jr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Day 23 Year **Physician** StECKLOW 5:45 P ™ 2008 Marc homAS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery <u> Arden Court Assisted Living</u> Kensington 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 5, 7. Age (In yrs. last birthday) **Funeral** Days 1**X**□M 2□F Yrs. 1912 95 Director 124-03-9519 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show at 1 Yes 2 No Kensington notified Director Maryland Montgomery 10f. Zip Code 20895 Og. Citizen of What Country?
United States 10e. Street and Number ö be 4301 Knowles Avenue 23a 7 Is marked other than "natural", or items 23s traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 ☐XNo Specify: Specify: à 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Contractor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)*Yetta Finestein and 2 should be fill tealth and Mental H m 27 Is marked oth Be Morris Stecklow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any injury or other trau 10315 Detrick Ave., Kensington, MD Arthur Stecklow, Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 ☐ Burial 2 ☐ Cremation Beth Moses Cemetery 103/27/08 Pinelawn, LI, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Full eral Service Lice Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ischemic Cardiomyopathy Physician /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and burial-tran Due to (or as a consequence of): physician Records, P.O. Box 68760 Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 2 No 3 Probably 4 ☐Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? /es 2 \(\) No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P Hospital or Attending Phys 24 hours after death. Funeral Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year) 25 MAR 2008

29b. Signature and title of certifier

Alpana Goswami, M.D., 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 27660

11125 Rockville Pike, Suite 110, Rockville, MD

29d. Date signed (Month, Day, Year)

08

20852

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

moomE

32 Registrar's Signature

BRECHER,

2008

31. Date filed (Month, Day, Year) MAR 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy Lipscomb Sauter March 2008 22:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Haure de Grace

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1920 Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20XF 220-09-5557 Yrs. 87 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours after death with the Marylar lith and Mental Hygiene.
27 is marked other then "naturet", or iteme 23e or 28e-1 ehow treumatic event, the Mudical Examil at must be notified at 1) Yes 2 □ No Directo Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 527 Ferdinand Drive 21078 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. ☑ Yes 2 Û No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Lipscomb Catherine Wright ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth Jean Gralewicz (Daughter) 527 Ferdinand Drive, Havre de Grace, MD 21078 important: If item. eny injury or other. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State V Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 4/2/2008 Baltimore, Maruland 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Foneral Service 123 S. Washington St. Havre de Grace. MD 21078 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line: Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Deludration 3 ☐ Probably 4 ☐ Hiknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 2 No 1 ☐ Yes After this certification funeral director, i 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours efter death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 (Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32609

Registrar
DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kamnedy Milhour To Hot K

32: Registrar's Signature

31. Date filed (Month, Day, Year)

APR 0 8 2008

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of contifie 29d. Date signed (Month, Day, Year) 2008 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 20634 Stephen Cafferty, MD 22333 Greenview Parkway, Great Mills, MD 31. Date filed (Month, Day, Year) 32. Registrans Signature State MAR 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician Edith Sole** 2008 March 21, 7:35 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Prince Frederick Calvert County Nursing Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 77 Yrs. Days Hours Min. 1 □ M 2 🗓 F Director Virginia January 18, 1931 226-32-2941 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f sh notified a 1 ☐Yes 2 🛛 No Director MD Calvert Prince Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or ms 23a must b USA 4324Cassell Blvd 20678 Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Cashier 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Margaret Waddle unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wind 2 portant: If item 27 Is n v Injury or other Brenda L. Dellinger - Daughter 4324 Cassell Blvd., Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury o Department 4 Donation 5 Dother (Specify) Maryland National Memorial Park 3/25/2008 Laurel. MD 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? res 2 No death? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No ဥ 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🛮 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.O. Records. Vita

Baltimore, Maryland 21215-0036

Physician Examiner the Hospital or Attending Physician: Division or Certification: hours after deat ineral Director: Fo the within 24 hours the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) impleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001 ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Maryland	-	artment			and Me		giene Reg. No.	HHR	142
	145		Decedent's Name (First, Middle	e, Last)						2	2. Date of Dea	ith		3. Time of Death
	Physici /Medi		Robert Harlan	STONER						Ma	Month arch	Day 26	2008	1:10pM
40	Examir		4a. Facility Name (If not institution	n, give street and numb	oer)		4b. City,	Town, or	Location o	f Death		4c.	County of Death	n
		31 °	Homewood Nursi				If Under		iams				Washin	
I.	Funeral Director		5. Social Security Number	6. Sex 7 1 M 2 □ F	Age (In yrs. la	st birthday) Yrs.	Months	Days	Hours	Min.	Month, Day	, Year)	. 1	nplace (State or Foreign untry)
397			214-09-6975 Usual Residence of Decedent	LL_	91					1	Aug. 7	191	6 Mar	yland
	ylanc how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Sa-1 s	cto	Maryland Washi	ington		Will	iamsp	ort						1 ☐ Yes 21 No
	or 20	Director	10e. Street and Number				10f. Zip					10g. Citi	zen of What Co	untry?
	s 23s	- CE	16505 Virgir	nia Avenue			2	1795		1.0.10			USA	
	Item Inerr	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marri	12. Was Deced	es?	. 13. (Yas Deced f Yes, spec	ent of Hi	n, Mexican	, Puerto Ri	fy Yes or No- can, etc.)		 Race - Amer Black, White 	
920	urs af	b	3 ☐ Widowed 4 ☐ Divorced	ff Yas Give	esWW II		I□Yes 2	X No	Specify:				Specify: W	hite
ဝို	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show its Medical Evarinar must be notified at	Completed		it's Education st grade completed)	WW 11	16a. Deced				of working		16b. Kir	nd of Business/I	ndustry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	lite. L	OO NOT us	e retired))	or working	′			
2	filed w Hygier Sther th		12	1		Elect	rical	& R			-		ircraft	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ms	Be	17. Father's Name (First, Middle,							,	First, Middle,		Sumame)	
2	should nd Men marke umaric	2	Moffett J. Sto 19a. Informant's Name/Relations			10b Mailin	a Addrass	(Street a			Shifler		r Town, State, Z	in Codel
<u>@</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at													
	Hea Hea Hem		Brent E. Layto 20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nam	ne of		reet,	, Hager	20c. Lo	wn, Md.	ZI/40 Town, State
e E	Pages nent of int: If it		1 Burial 2 Cremation 4 Donation 5 Other (S		ate	metery, cren	•					******	**************************************	**
altimore,	교투론급 .		21. Signature of Funeral Service		OA TO	22	. Name and	d Addres	s of Facility			Test.	neral H	Maryland
m	Depa Impo eny to		Scot	X MI	Hen	116	25 E.	Wil	son I				n. Md.	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that car	sed the death.	Do not ente	er the mode	e of dying	, such as	cardiac or r	respiratory ar	rest,	1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Ah	PROGE	prox	- /	Com	lia	116	rula	1	livan	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseque	ince of):								100
ı	LAUTHITET	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to for	as a conseque									
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	d Due to (or	as a conseque	ince or):								
	ate be executed hysicien and the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):								
8760	ate be ex hysicien the buria													
9	ifficate g phys as the	Physician/Medical		0.										
Вох	The law requires that the death certific Ne hes been signed by the ettending p page 2 should be detached for use as:	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnand		Ectopic pre	2002001				2	23d. Date of deli	very
	ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of dea		Other (spe						Month	Day Year
<u>Ч</u>	that the de ed by the detached	Phy	9 Unknown											
S,	res tha signed be de	δ	Part II. Other significant condition	ons contributing to dea	in but not result	ing in the ur	iderlying ca	ause give	n in Part I.					the cause of death?
ö	w require been si should t	eted	Dendary	·						_	-	es 2	NO SELEC	obably 4 Unknown
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ō	g Phys ter this neral di	$ \vdash $	27. Manner of Death	28a. Date of (Month,	atient 2 ☐ Ei Injury 2	8b. Time of		Bc. Injury Work	4 Nu		d. Describe h		Other (Spec	cify)
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Division of	or Atten after deat Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could i	ined 288. Place of	Injury - At hom	ne, farm, stre	et, factory,	office		281	f. Location (S City or Tow	treet and	d Number or Ru	ral Route Number,
ā	tal or A	Cer		bunding	, etc. (Specify)						Only of TOW	n, State)	,	
	To the Hospital or Al within 24 hours after of To the Funeral Directompletely filled in by	edicai	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the b Examiner. On the bas	is of examination	ledge, death on and/or inv	occurred a estigation,	at the time in my op	e, date and inion, deat	d place, and h occurred	d due to the d at the time, d	ause(s) late and	and manner as place, and due	stated. to the cause(s)
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			1///	MIN		•		D 2	6 f	06		$\mathcal{M}_{\mathcal{O}}$	rd_2	6 2008
/			30. Name and odd ss person	who completed cause	of death (Item 2	23a) (Type,	Print)		0.	11	. /	1	A	6, 2008 D 21742
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Recording Part ANN THORPYON Security Part Content of Death County of D			Registrar 1. Decedent's Nam	ne (First, Midd	le, Last)		-	Ce	rincai	OIL	Jean		2. Date of D	Reg. No.	241	0	3. Time of Death
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State Registrar A Homicide Building, etc. (Specify) City or Town, State)	death ctor: y the	icat		6 ☐ Could	not be	e. Place of	iniury - At h	ome, farm, st			162 2	7140	28f. Location	(Street an	d Numher or	Rural F	Route Number
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State Registrar Jenn (or B dela Kosa Di) GGOZ Church Hill Kd Sulla 200 Chestatown MD 21620 31. Date filed (Month, Day, Year) 32. Registras Signature ARR 2 8 2008 Month Chestatown MD 21620	4			ress of persor	who complet	ted cause	of death (Ite	m 23a) (Type,	, Print)	· L -	2 4	ر_	lant	۵ مه	10,10	O	
Registrar MAR 2 8 2008 Mexico S Signature				dela Ko.	sa 00	6602	Church	1 Holl &	d Sul	6 2	100	ches	TO 10WN	מות	2162	.0	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Edith B. Tillotson 20, 2008 March 6:45 A.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1□M 21 F Director 318-03-6798 Aug. 1, 1911 Illinois Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Worle 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f ehov the Medical Examiner must be notified at Director 1 √2 Yes 2 □ No Maryland | Montgomery Rockville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6121 Montrose Road 20852 U. S. A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Deperment of Heelih and Mental Hygiene. important: if item 27 is marked other than "natural", or iten any injury or other treumatic event, the Madical Examinat Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White þ Specify 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 Years Elementary/Secondary (0-12) Interior Decorator Decorating 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Block Minnie Kislov ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20007 David Tillotson - Son 4606 Charleston Terrace, N.W., Washington, D. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 3/21/2008 Falls Church, Virginia 21. Signature of Funeral Service Licensee Faward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland Donald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of): Examiner TIFIED OAGANISM MIDEN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4□Pregnant at time of death signed by the et 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No should 2/16/ 1 Tyes 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? certificete 1 Yes 2 No. of Vital 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending Division 1 Natural 5 Pending investigation Injury death. М Director: 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Atterwithin 24 hours after des To the Funaral Director completely filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) user D018084 ell uin. MARCH 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. GIZI MONTROSE RD, ROCK VILE MD 20852 PATEL INESH 31. Date filed (Month, Day, Year) 12 legistrar's Signature State

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Registrar

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e de la companya de l	Physici /Medic		Decedent's Name (First, Middle, Last) Antonia Vacca		Date of Death Month	Day Year 22 2008 6:29 P M
)	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) May 28, 1	4c. County of Death Frederick 9. Birthplace (State or Foreign Country) 1919 Italy
	<u> </u>	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick 10e. Street and Number 825 Waterford Drive			10d. Inside City Limits 1 TYes 2 No No. Citizen of What Country? U.S.A.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at	Completed by Fune	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	as Decedent of Hispanic Origin? (Spx 'es, specify Cuban, Mexican, Puerlo Yes 2X No Specify: nt's Usual Occupation and of work done during most of work NOT us retired)	[16	14. Race - American Indian, Black, White, etc. Specify: White Sb. Kind of Business/Industry
ylang z	be pd of d	To Be Col	17. Father's Name (<i>First, Middle, Last</i>) Luigi Del Do	Maria Fre		
	t and 2 Health : em 27 i ther tra		Madeline J. Maffiotto / Daughter 825 Wa 20a. Method of Disposition 20b. Place of Disposition	· · · · · · · · · · · · · · · · · · ·	rederick	,
Baltimore,	permit. Pages Department of Important: If it any injury or o		4 Donation 5 Other (Specify) 21. Signature of Euroral curvice Lightness Arlington 22. No.	Nat. Cem. 4/7/0	SON. FUNER	lington, Virginia AL HOMES, P.A.
	Physician /Medical Examiner		23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	the mode of dying, such as cardiac of	respiratory arres	EDERICK, MD 21701 Approximate Interval Between Onset and Death
68/60,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
P.O. Box o	at the death certificate by the attending physic tached for use as the b	Physician/Med		ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Hecords,	The law requires that the death certifica tate has been signed by the attending phyage 2 should be detached for use as the	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		cco use contribute to the cause of death? 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Munknown} \) 24b. Were autopsy findings available prior to completion of cause of death? 3\(\text{No} \) 1 \(\text{Ves} \) 2 \(\text{No} \) No
or vital	siclan; certific rector,	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatient	3 □ DOA Other: 4 □ Nursing Ho	n <i>(Check only one)</i> me 5 ☐ Residen	ce 6 □Other (Specify)
DIVISION	y Phys er this eral dii	Certification:	27. Manner of Death 1.★Natural 5 □ Pending investigation 2 □ Accident 3 □ Sulcide 4 □ Homicide 6 □ Could not be determined 5 □ Pending investigation 3 □ Sulcide 6 □ Could not be determined 6 □ Could not be building, etc. (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Mont	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how 28f. Location (Stre City or Town,	et and Number or Rural Route Number,
	the Hospit nin 24 hour the Funera npletely fille	edical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death of the best of examination and/or invested and manner stated.	stigation, in my opinion, death occur	red at the time, dat	te and place, and due to the cause(s)
)	or with	Σ	29b. Signature and title of certifier La Mont South, MD	29c. License number D005 295		d. Date signed (Month, Day, Year) Narch 23, 2008
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr Lamont C. Smith, MD 400 West 7th Streems 1. Date filed (Month, Day, Year) 32. Registrar's Signature	eet, Frederick, M	D 21701	
DI	Sta Registr	ar	MAR 2 6 2008	grades		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#1 . Per Phys . PC3-24-08cm Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death · Sonia Daysi Vidals - Balmes Day Month Year **Physician** 12:01 MARCIN 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yrs. Months Days Hours Min. Sept 7, JOHNS MOPKINS Birthplace (State or Foreign Country)
 Mexico 5. Social Security Number 6. Sex **Funeral** None Director Usual Residence of Decedent death with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10h. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 TXYes 2 □ No Maryland Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 637 S. Newkirk Street 21224 Mexico Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ≝Yes 2□ No Specify: Mexican altimore, Maryland 21215-0036 Specify: White <u>6</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodian Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othy any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Javier Vidals Audoxia Josefina Balmes Cortez 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maria Vidals (Sister) 637 S. Newkirk Street, Baltimore MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State Panteon Municipal Cem. 3/27/2008 Guadalupe Santana, Mex. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRendon/Hale Funeral Home 21. Signature Funeral Service Licenses 9013 Annapolis Road, Lanham MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBELLAR n GOORRHAUTE IDAY SHOUR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MAYORMAMON ARTERIO-VENOUS UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 200 certificate 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 2 No 1 ☐ Yes 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D0062448 M.D HARCH 19, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 4940 EASTERN AVENUE, BAYIMORE NO 21224 NEE MAS NAVA 32. Registrar's Signat 31. Date filed (Month, Day, Year) State MAR 2 4 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear Genevieve Dolores Welle 19, March 9:16 A 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare Anne Arundel Severna Park If Under 1 Year If Under 24 Hrs.

Management of the second 5. Social Security Number Date of Birth (Month, Day, Year) 6. Sex Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2**X** F 85 219-16-3194 Director Mar. 12,1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show at items 23a or 28a-f shiner must be notifled MD Anne Arundel Severna Park Director 1 ☐ Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 392 North Drive 21146 USA 1 2 should be filed within 72 hours after death vand Mental Hygiene. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, r than "natural", or iter the Medical Examiner Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Adam Watkowski Frances Witkowski 1 and 2 should ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Conrad Gene Welle/ Son 5018 Rippling Road Cambridge, Maryland 21613 nt of Health a If item 27 ls or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20c. Location - City or Town, State permit. Pages Department of I Important: If ite any Injury or of 1 XBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) March 25, Holy Rosary Cemetery Dundalk, Maryland 2008 22. Name and Address of Facility Barranco & Sons, 21. Signature of Furieral Service Licer Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 15 chemic **Physician** cardiomipoath disease or condition resulting in death) ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-tran Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 mor Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) P.0. detached ed by the 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown . Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 No certificate death? 1 ☐ Yes 1 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation within 24 hours area Corrector: Aff 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

29d. Date signed (*Month, Day, Year*) 8

ranstruy M, Hersv. Up Mi) 21108

impleted cause of death (Item 23a) (Type, Print)

and manner stated

31. Date filed (Month, Day,

nature and title of certifie

MAR 2 4 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Sidney WINTER March 24, 2008 11:15 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 15, 1921 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F Director 069-16-6648 86 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f show the notified at Maryland Montgomery Silver Spring 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20901 301 Burnt Mills Avenue an "natural", or items 23a Medical Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nealth and Mental Hygie m 27 is marked other th Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Menachem Mendel Winter Esther Cohen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. 301 Burnt Mills Ave., Silver Spring, MD Kalman Winter, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olives Cemetery 03/26/08 Israel 21. Signature of run ral \$e vice Licer ee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arterioschootic caldivascu **Physician** VPa /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecuence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) o 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed Vital 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA Division or 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pon 24 hours after death.

Permeral Director: After the Funeral Director; After the felled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Minchesman, mo 55410. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /2 years y Enclosinan, in D. 860001d Georgo Four Rd, Benesida, m.D. 20814.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAR 25

2008

32 Registrar's Signature

			For	State of Marylan	d / Dep	artment of H	lealth and I	Mental Hyg	iene	
		•	1 - State Registrar		Ce	rtificate of	Death	Re	eg. No. 2008	1428
lisk	Dhyaisi		1. Decedent's Name (First, Middle, La	st)				Date of Deat Month	h Day Year	3. Time of Death
A) Share	Physici /Medi		Mary Ann Wi	lding					23, 2008	2:59 p ^M
>	Examir	ner	4a. Facility Name (If not institution, giv				Location of Death	1	4c. County of Death	
			Subusban 1	109pital		Beth	586(14C	I o D i c o D i i		کے وہ سون
	Funeral		5. Social Security Number 6. S 579-46-6154	ex	as <i>t birthd</i> ay Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Cour	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	12				Jan. 15	, 1936 Wash	ington, DC
	show sdat		10a. State 10b. County	10c. City	, Town or L	ocation			1	10d. Inside City Limits
	e Mar a-f sl	ctor	Maryland	Montgomery		Bethesda				1 □Yes 2t☑No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Cour	ntry?
	ath w		6331 Tone Drive			20817		US.		
	er de items	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
36	rs aft P', or xami	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ted	15. Decedent's Ed	ducation		edent's Usual Occup		. 1	l 16b. Kind of Business/In	dustry
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nd	be file tal Hy d oth even	Be	17. Father's Name (First, Middle, Last,					ne (First, Middle, M -	flaiden Surname)	
yla	2 should be filed v and Mental Hygie Is marked other t raumatic event, th	은	Anthony W. Wildin		T		Dorothy			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryle I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (James A. Wilding)		19b. Mail				City or Town, State, Zip	
	Health tem 27		20a. Method of Disposition	20b. P	lace of Disp	osition (Name of	i		20c. Location - City or To	
D .	Pages 'nent of H		1 ☑ Burial 2 ☐ Cremation 3 ☐	Hemoval from State	-	ematory or other place Heaven Ce		arch 27	-	
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other		4 ☐ Dorration 5 ☐ Other (Specifical Service) Licer	· ·					Silver Spri Home Inc.	ng, Maryland
B	permit. Departn Importa any inju		* MUMOULE X C	DONKOON					Home Inc. lver Spring	MD 20001
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death						Approximate Interval Between
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	/Medical		resulting in death)	a. Due to (or as a consequ	ience /i.	1		1		000
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	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of): \		1			mF
_	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	хап	that initiated events resulting in death) Last	cDue to (or as a consequ	lence of):	+			mo) γ ' ' ' ' ' '
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687	ficate physics the t	edical		_d		Ar	4	27	4	
Вох	leath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna		0 \		2/24/5	23d. Date of delive	ery
Ď.	death a atte d for	icial	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2□Fetal 4□Pregnant at time of de		□Ectopic pregnancy □ Other <i>(specify)</i> _	y* -	2	Month	Day Year
P.0	at the de by the tached	hys	9 Unknown	9□Unknown						
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Records,	w require been sig should b	ted	<u></u>					1 □ Ye	es 2 □ No 3 □ Prot	pably 4 Onknown
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or Vital	dir	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 💆	ER/Outpatie 28b. Time o	ont 3 DOA Oth	4 LI Nursing H		nce 6 Other (Special	
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Ö	al or after	erti	4 ☐ Homicide determined	building, etc. (Specify	rep	t		B. T. City or Town	reet and Number or Run , State)	icus due
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, dea	th occurred at the ti	me, date and place	e, and due to the ca	ause(s) and manner as s	stated.
	the H in 24 the Ft	ledical	(Check only 2 Medical Examone)	niner: On the basis of examinat and manner stated.	uon and/or ii	rivestigation, in my o	phillion, death occi	arred at the time, da	ate and place, and due t	o tne cause(s)
	With Voil	Σ	29b. Signature and title of certifier	Schechner mo		29c. Licens	e number 56414	29	9d. Date signed (Month,	
	20		6/8-						March 23,	2000
			30. Name and address of person who Adam J. Schechner	completed cause of death (Item , MD 6420 Ro	23a) (Type	ge Drive,	, Bethesd	la, MD 20	817	

Registrar DHMH 17 Rev 1/2001

ORIGINAL

State

31. Date filed (Month, Day, Year)

MAR 2 5 2008

32 Registrar's Signature

			For State		State o	of Maryla		artment of H				- 2	008	111,29
	ž.		Registrar 1. Decedent's Name (First, Mi	ddle, Lasi	r)			Tillicate of	Dealii		2. Date of Dea	Reg. No ath	000	3. Time of Death
84	Physici		Paul F. Wat	son							Month March	Day 23 2	008	3:10 p M
A. Carlo	/Medic Examir		4a. Facility Name (If not institu	tion, give	street and nu	mber)		4b. City, Town, o	r Location of	of Death		<u> </u>	ounty of Deat	
			Carriage H	.11 c	f Beth	esda		Ве	thesd	a			Montg	omery
8.	Funeral		5. Social Security Number	6. Se	x □M 2□F	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Year)	9. Birt	hplace (State or Foreign
ŀ.	Director		037-16-8801	1-0		79	Yrs.	ovalo Bayo	, iodio		May 2,			de Island
	and w		Usual Residence of Decedent 10a. State 10b. Cou	ntv		10c, C	ity, Town or Lo	ocation						10d. Inside City Limits
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	the 28a-	rect	faryland 10e. Street and Number					10f. Zip Code				10g. Citizei	n of What Co	untry?
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	ms 2:	Jera	8100 Connect i	cut	12. Was Deci	edent Ever in U	J.S. 13.	20815 Was Decedent of H If Yes, specify Cub	lispanic Ori	igin? (Spe	cify Yes or No-		SA Race - Ame	rican Indian,
ပ္	after or ite	Funeral	1 ☐ Never Married 🏖 №	arried	Armed Fo	2 No		_			Rićan, etc.)		Black, White	
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5	filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Deced (Specify only hig	ent's Edu hest grac	ication le completed)		(Give	dent's Usual Occup kind of work done	durina mos	st of worki	ng I	16b. Kind	of Business/	Industry
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N D	Hygie Ther i	ပိ	17. Father's Name (First, Midd	le last)	4		ET	ectrical			(First, Middle,			dustry
Maryland 21215-0036	d be ental	o Be	Paul F. Watso	•							Wellman		irramej	
Z Z	shoul nd M marl mati	မ	19a. Informant's Name/Relation		/pe. Print)		19b. Mailii	ng Address (Street					own. State. 2	Zip Code) 20815
Š	alth a 27 is		Marie Watson/W	life				Connect						
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition				Place of Dispo	sition (Name of matory or other place	ce)		late	20c. Local	tion - City or	Town, State
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ä	eparti eparti porti ny Inj		21. Si ye ture - uneral ervi	ce y cens	7//	21	22	Name and Addre	ss of Facilit	llins	Funera	al Hor	me Inc	•
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			23a. Part1. Enter the disease shock, or heart failure. L	or compl ist only o	lications that one cause on e	caused the dea each line.	th. Do not ent	er the mode of dyir	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
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<u>.</u>	that t ed by detac		Part II. Other significant cond	itions co	ntributing to de	eath but not res	sulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
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DIVISION	I or Attending Phys after death. Director: After this I in by the funeral dii	Certification:		rmined	28e. Place buildi	of injury - At hing, etc. (Speci	ome, farm, str fy)	eet, factory, office		2	28f. Location (S City or Tow		lumber or Ru	ıral Route Number,
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	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	Me	29b. Signature and title of certi	fier				29c. Licens	e number			29d. Date s	igned (Month	n, Day, Year)
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	Sta Registra		31. Date filed (Month, Day, Yea MAR 2 5			legistrar's Sign	K A	WE !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02408 Jane E. Wilensky State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Year Medical Examiner 2226 hrs March 26, 2008 Jane Wilensky 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 3253 Normandy Woods Drive Apt D Ellicott City Howard If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Country) Months Davs Hours Min Director 1 M 2 X F 45 10/11/1962 Wash. D.C. 219-90-6720 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No 28a-f show narked other than "natural", or items 23a or 28a-f sho event, the Medic al Examiner must be notified at once. MD Howard Ellicott City Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe 3253 Normandy Woods Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Yes 2 X No specify: Specify: White Divorced f Yes. Give Yea Widowed ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica Manager Dental Office 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Julius T. Wilensky Elaine Nannis 19a. Informant's Name/Relationship (Type, Print) **Julius** Theodore T. Wilensky — Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0906 2900 N. Leisure World Blvd #510 Silver Spring, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date Baltimore. crematory or other place) 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify. Judean Mem. Gdns. 3/30/2008 Olney, Maryland 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc 21. Signature of Funeral Service Licenses Rockville Pike Rockville. MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Medical Death a. Pro exyphene Intoxication Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Gaussi (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/22/08 amh X UNPENDED has been signed by the attending physician 2 should be detached for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be evithin 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the finneral director, page 2 should be cleached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Year 3 Ectopic pregnancy Day Live birth Fetal death Month Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 V No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 ✔ Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Yes 2 X No 1 Natural Pending Fnd 3/26/08 Fnd 10:15a lnk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Joyn, State) 3253 Normandy Woods Dr. Apt. D, Elliott City, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide determined (Specify) Found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certification March 27, 2008 O.C.M.E. ho completed cause of death (Item 23a) 30. Name and address of person y Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signat State 2008

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Registrar

OCME

			1 - State of Maryland State of Maryland		artment of F rtificate of I			giene Reg. No.	300	1143
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Mack Lloyd Wilt				2. Date of Dea Month Mar 21	th 2008	Year	3. Time of Death
, ,	Examir		4a. Facility Name (If not institution, give street and number) Larkin Chase 5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	Bowie If Under 1 Year	Location of Death	8. Date of Birth	1	e Geo	orge's
	Director		579-38-4214		Months Days	Hours Min,	(Month, Day 8/8/192		Ohio	
	a-f show	ctor		Town or Loc	cation				11	0d. Inside City Limits 1 X Yes 2 □ No
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Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Plac	ce of Dispos netery, crem	sition (Name of natory or other place	e) [Date	20c. Location -		,
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22.	. Name and Addres	s of Facility			altimo	ore Ave. , MD 20781
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	ipital or Attendous after death ours after death leral Director: , filled in by the f	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, stree		es 2 🗆 No	28f. Location (Sti City or Town	reet and Numbe , State)	er or Rural	Route Number,
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	So man		29b. Signature and title of certifier 3MJ)	29c. License D00452			od. Date signed		
R	+1	;	30. Name and address of person who completed cause of death (Item 23). Abebowale Ajayi 6201 Greenbelt		rint)				, 2000	
	Stat Registra	-	31. Date filed (Month, Day, Year) MAR 2 5 2008 32. Registrar's Signature		, oreembe	rii Zl	7770			

		For State Registrar	State of Maryland / D		ealth and M	ental Hygid	_	111.20	
4	2.1	Decedent's Name (First, Middle, La.				2. Date of Death	2000	3. Time of Death	
Physicia /Medio	al	JOHN	THOMAS	WEBB		Month	Day Year 2008	10:10 AM	
Examin	er	4a. Facility Name (If not institution, give	·	4b. City, Town, or			4c. County of Dea		
		2101 Jerrys Ro			Street If Under 24 Hrs.	8. Date of Birth		rford	
Funeral Director		205-16-6243		Months Days	Hours Min.	6/1/19	(ear) Co	thplace (State or Foreign ountry) [aryland	
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits	
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permit. Departr Importa any injt		21. Signature of Fungral Service Liger	isee () Lil	22. Name and Address	s of Facility Ja	rretts	ville, M	arvland	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical	29a. Certifier 1 ertifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the tim	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	se(s) and manner as e and place, and du	s stated. e to the cause(s)	
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		30. Name and address of person who	complete a se of death (Item 23a) (T	Type, Print)	21/04	(a. +	XI.	12008	
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		For	State of	Marylar	nd / Depa	artme	nt of H	lealth a	and M	ental	Hygien	e		
	-	State Registrar			Ce	rtifica	te of i	Death			Reg. N	lo. 20	0.8	1143
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Physicia /Medica		Beth Lorene Wa	arren								ch 22		rear }	13:45 P M
Examine		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City	, Town, o	r Location	of Death			4c. County of Death		
		Calvert Memoria	1 Hospita	1		Pr	ince	Frede	erick			Calve	rt	
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"nat		15. Decedent's Education 16a. Decedent's Usual Occupation 16b. If (Give kind of work done during most of working life. DO NOT use retired)									Kind of Busi	ness/In	dustry	
withir than than	mp	Elementary/Secondary (0-12)	College (1-4	or 5+)				1)				1 ممالم	L	ealth care
hed v	ပ္ပြဲ	12	ot)		Se	cret	ary	19 Moth	ar'e Nama	/Eirct M				earth care
ntal H	å	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, M										ŕ	,	
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1 and Health Sm 27 ther to	. 7	Brandon Shane Wa	rien, son	20h	Place of Dispo			OK COL		ate	-	D 2073 Location - C		own State
permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		11X Burial 2 □ Cremation 3		ate	cemetery, cre	matory or	other place	· ;						wii, State
t. Pa		4 Donation 5 Other (Spe		M	t. Harı						- 1	ings,		
permi Depa Impol any Ir		21. Signature of Funeral Service Lic	ensee									al Hom		
ED = # 0		Wollon Y:	arw-					No. of Street, or other Persons				s, MD	207	
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau ly one cause on eac	sed the dea h line.	th. Do not en	ter the mo	ode of dyin	ng, such as	cardiac o	r respirat	ory arrest,			Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	_a Kes	pira	tous	-	tail	w	re					Oliset and Death
/Medical Examiner		resulting in death)	Due to (o	as a consec	quence of	, J		P						
20. 46		Sequentially list conditions,	b. Tet	asta	tit l	une	3 (an	cer					
p #	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury												
ecute and tran	cam	Cause (Disease or Injury that initiated events c. Due to (dr as a consequence of):												
		,	Co Co	O CONSEC	quence (ii).),,	. H	•	_					
ate t	dical	d. marac wry 14 ma											\rightarrow	
		IF FEMALE:	00- 11											
Attending Physician: The law requires that the death certificrate the actions of the attending ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 ponths?	23c. If yes, outco 1□Live birt	h 2□Fet	al death 3	Ectopic		y				23d. Date Mont		ery Day Year
the a	Sic	1 ☐ Yes 2 1 No 9 ☐ Unknown	4□Pregnar 9□Unknow		death 5L	Other (s	pecify)							,
w requires that the d been signed by the should be detached	<u>و</u> ا	Part II. Other significant conditions	contributing to dog	h but not roc	aulting in the u	undorlying	causa siy	on in Bort I	-	220	Did tobacco	Luco contrib	uto to t	he cause of death?
ires ti signe	5	Tarrii. Other signinoam conditions	recontributing to deat	II Dut Hot les	salang in the a	indenying	cause giv	eninratti			1 LYes			pably 4 Unknown
requi	Completed										T L CS	2 100 3	- FIOL	Jably 4 Conknown
e law has b	٩										Was an autopsy	pri	ere auto	psy findings available mpletion of cause of
The	5									1 1	performed? /es 2	No 1E	ath? ⊒Yes	2□ No
sician: The k	Be	25. Was case referred to medical examiner?							of Death	(Check o	only one)			
Physical this call dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 pmp] ER/Outpatie			4 LI NU	rsing Hor	ne 5 🗆	Residence	6 □Other	(Specia	5y)
ding Ph	;;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time o	of	28c. Injur Wor	y at k?	2	28d. Desc	ribe how in	jury occurre	d	
tendi	Sati	2 ☐ Accident investigati	ho			M		Yes 2	No					
ter d ter d irect	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	Zoe. Place of	injury - At h , etc. <i>(Sp</i> ec <i>i</i>	iome, farm, st <i>ify)</i>	reet, facto	ry, office		2	28f. Locat City o	ion (Street a or Town, Sta	and Number ate)	or Rura	al Route Number,
Hosp 4 hou Fune Tely fi	ca	(Check only 2 Medical Ex	Physician: To the be aminer: On the basi	s of examin										
the hin 2 the label	Medical	(Check only one) Amedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29c. License number 29d. Date signed (Month.												
To Too	-	29b. Signature and title of certifier				2			~=	_		ate signed		-
		* AND	ornw				S	75	88		Mal	cch 2	4,	2000
, ,		30. Name and address of person whe Rafik A. Nasr,					Curi	to #2) T 11	shv	M⊃ rv	land ?	065	7
W 6						TIVE	Jul	UC #2	., шu	any,	rary.	Lanu Z		
Stat	е	31. Date filed (Month, Day, Year)		istra Sign	ature	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

2008

ORIGINAL

altimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

UMA

APR 0 9 2008

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

BUSINESS

32. Registrar's Signature

29c. License number

CENTER DRIVE REISTERS TOWN

29d. Date signed (Month, Day, Year)

08-02147	
Carmen Alston	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

armen Alston			nt of Health and Mental Hygiene le of Death Reg. No. 2008 143										
Physician Medical Examina	1/	Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year March 16, 2008 3. Time of Death 1559 hrs										
neulcai Exammie		Carmen Alston 4a. Facility Name (if not institution, give street and number)	March 16, 2008 1339 IIIS 4b. City, Town, or Location of Death 4c. County of Death										
		Prince Georges Hospital	Cheverly Prince George's										
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	lay) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or										
Director		182-24-2189 1_M 2KF 82	Yrs. Months Days Hours Min. 6/22/1925 Foreign Phil Country) Pa.										
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location 10d. Inside City Limits										
10 W 21	.	DC Washin											
rylanc ka-f sh	흸	10e. Street and Number	10g. Citizen of What Country?										
The Me Me	Director	26 33rd Street N.E.											
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinet must be notified at once.	ᇎᅡ	11. Marital Status 12. Was Decedent Ever in U.S.	3. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,										
death or iter	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.										
s after ral",		3 X Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify: Specify: Black										
"natu	Completed by		ucedent's Usual Occupation (Give kind of work done ring most of working life. DO NOT use retired)										
336 Jhin 72 Je. than diral	톍		nemaker Private										
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	탉	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)										
121 be fill be fill rrked vent,	å [Carmen Agularia	Minnie Pitts										
D 2 should and Minatic e	2		Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
and 2 ealth 2 tem 2	ŀ		eacon Hill Drive Bloomfield, CT. 06002 Disposition (Name of cemetery, Date 20c. Location - City or Town, State										
iore	-	1 X Burial 2 Cremation 3 Removal from State cremator	y or other place)										
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and I Important: If Itien 27.	4 Donation 5 Other Specify: Arlington National 4/8/2008 Arlington, VA. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityPope Funeral Homes, P.A.												
Department injury		Two L. Hennimas	5538 Marlboro Pike Forestville, Md. 20747										
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and										
/Medical	1	Immediate Cause (Final disease a. Atherosclerotic Cardio											
	or condition resulting in death) Due to (or as a consequence of):												
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated											
d ansit	ដ	events resulting in death) Last Due to (or as a consequence of): d.											
, P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit of the Deutsian Medical Examples.	Medical	X UNPENDED AMENDED 23a,27 per ME g	878 4/21/08 amh										
760 icate b physi	Ĕ.	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery										
certification continues as as	i g	past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Month Day Year										
Box death	Physician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)										
or the sat the set by t	2	Part II. Other significant conditions contributing to death but not resulting it											
S, P			1 Yes 2 No 3 Probably 4 Unknown										
tal Records, cian: The law requirectificate has been sector, page 2 should	Completed		24a. Was an 24b. Were autopsy findings available prior to completion of cause of										
Rec The la	ξĺ		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No										
tal Rection: The certificate ector, page	De C	25. Was case referred to medical examiner?	26.Place of Death (Check only one)										
Physic Physic er this	<u> </u>	1 ✓ Yes 2 No Inpatient 2 ✓ ER/Out											
n of ding Pt		27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Tit	ne of Injury 28c. Injury at Work? 28d. Describe how injury occurred										
Sior Attend r death ector: by the		2 Accident Investigation 28e Place of Injury - At home farm	n, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City										
Division o spital or Attending tours after death. neral Director: After filled in by the fune		3 Suicide 6 Could not be determined (Specify)	or Town, State)										
Hospi 24 hou Funer ely fil	- 1	200 Cortifier	occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The taw requires that the death certificate be executed to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification. To Be Completed by Direction Medical Expenditual Expensions of the complete of the control of the cont	ğ		estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
F 3 F 00	¥⊨	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)										
/		Jash Jeef up	O.C.M.E. March 17, 2008										
1		0. Name and address of person who comp — d cause of death (Item 23a)											
	ĺ		111 Penn Street, Baltimore, MD 21201										
Stat Registra	e ar	31. Date filed (Month, Day, Year) 2008 32 segistrar's Signature of the Company of	for the										
- regions													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician 07 2008 Cornell Milton Brooks /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hospice of Chesapeake (Tate) Linthicum Ann Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 06-29-1918 5. Social Security Number .Sex †∐M 2□F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 89 217-09-5967 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygjene. Int: If them 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show notified at 1 ☐ Yes 2 ☑ No Director MD Ann Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 211 Cedar Hill Lane 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Yes 2 No
 Yes, Give
 ear or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) Small arms Technician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Brooks Calla Dotson P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Lyles Niece 6210 Cheverly Park Dr, Cheverly, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other (Specify) Intombment Cedar 4/12/2008 Baltimore, MD Hill 22. Name and Address of Facility
W.Wesley Chavis III Funeral Service P.A.
10684 Southern MD BLVD Dunkirk, MD 20754 21. Signature of Funeral Service Licensee MD_20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 115 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be exect Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending phase as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No , 24a. Was an page 2 s autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) p) ce examiner? 1 Yes Other: 4 Nursing Home 5 Residence ို 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 9 ☐ Other (Spec HOWK After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation **D** Natural 2 Accident 1 ☐ Yes 2 ☐ No after death 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar Name and address of person who completed cause of de

31. Date filed (Month, Day, Year) APR 0 9 2008 eath (Item 23a) (Type, Print)

30

M

32. Registrar's Signature

			For State	State of Marylan				Mental Hy	giene				
	AND THE RESERVE OF THE PERSON		Registrar 1. Decedent's Name (First, Middle, Last		Cei	rtificate of I	Death	100110	Reg. No	18_	11438		
	Physici	an						2. Date of De Month	Day	Year	Time of Death		
	/Medic		APRIL TOWANDA BLA 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Door	MARCH	13, 2 4c. County	008	8:06 A [™]		
	Examir	er		street and number)				III	4c. County	or Death			
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	BALTTMC If Under 1 Year	If Under 24 Hrs		rth	9. Birthpla	ce (State or Foreign		
٤. ۽	Director		212-86-6555	∃м 2 ∑ ғ 32	Yrs.	Months Days	Hours Min.	APR. 8		Countr	MD		
	pu ,		Usual Residence of Decedent		T			111111	1010				
	aryla shov	-	10a, State 10b, County	Toc. Cit	y, Town or Lo	cation				100	d. Inside City Limits1 XYes 2 □ No		
	the M 28a-f otifie	Director	MD 10e. Street and Number	BA	LTIMOR				40- 0111				
	a or					10f. Zip Code			10g. Citizen of W	mat Country	y?		
	leath	Funeral	206 MASON CT.	12. Was Decedent Ever in U.	S. 13. V	21231 Was Decedent of H	ispanic Orlgin? (9	Specify Yes or No	USA 14. Race	- Americar	Indian.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	i	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2☑ No	Specify:	to Rican, etc.)		R, White, et	c.		
21215-0036	72 hou natura lical E	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu	16b. Kind of Business/Industry			
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	led w tygier her th		10TH		HOM	EMAKER	40.14.15.15.15	/mi	HOME				
anc	l be fi	Be	17. Father's Name (First, Middle, Last)					•	e, Maiden Surname	9)			
Maryland	hould d Me mark matic	မ	JAMES FIELDS 19a. Informant's Name/Relationship (Ty	rne Print)	19h Mailir	ng Address (Street a		BLACKMAI		Ptoto Zin C	Pada)		
₹	nd 2 s lith ar 27 is r trau		BETTY BLACKMAN/MO	•					-				
ē,	f Heal		20a. Method of Disposition	20b. P	lace of Dispo	5 E. MADI sition (Name of	i	Date Date	20c. Location 7	2120: City or Tow			
OE.	Page: ent o nt: If		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		natory or other plac	i i	06/2000	BALTIMO				
Baltimore,	mit. partm sorta / Inju		21. Signature of Funeral Service Licens	ee		CARMEL Name and Address	ss of Facility WF	SLEY CH	AVTS TR	ENIRI FINIRI	D 21224		
m	a m De		100	mo1358	-				ALTIMORE		21231		
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	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):								
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	ted nsit	Examiner	Cause (Disease or injury	. 1 .	20.19	and a sign							
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68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		4									
	tificat g phy as the												
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<u>.</u>	e deat	sicia	in the past 12 months? 1 ☐ Yes 2 🗷 No	4□Pregnant at time of d		Other (specify)			Mor	ith D	ay Year		
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'n	res th	þ	Part II. Other significant conditions con	cular Acciden	-	4			tobacc se contri				
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ō	Phys rthis raldi	<u>د</u>	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of	1 3 DOA	4 ☐ Nursing F		dence 6 Othe				
Division or	tending Physician: The leath. tor: After this certificate he the funeral director, page	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	ໃດ Yes 2∐No	200. Describe	now injury occurre	,u			
N S	Atter r deal ector by the	fica	3 Suicide 6 Could not be	28e. Place of injury - At ho					Street and Numbe	r or Rural F	Route Number,		
	al or At s after d al Direct ed in by	Certification:	4 ☐ Homicide determined	building, etc. (Specify	′)			City or To	wn, State)				
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director; g	edical (29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the time vestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and mar date and place, a	nner as stat nd due to ti	ed. he cause(s)		
	To th within To th comp	Me	29b. Signature and title of certifier	,		29c. License	number		29d. Date signed	(Month, Da	ay, Year)		
			Clarke Fr	and MD		Doos:	3352 h	17	4/7/	UR.			
•	1	ŀ	30. Name and address of person who co	empleted cause of death (Item	23a) (Type, I	Print)	12 2 1		(/ -/				
	ン		Charles E. Davi	S, JV. mD. 16	. S. Er	Jaw St.	Baltimi	ve, m)	2120,	1			
	Sta Registr		31. Date filed (Month, Day, Year)	ompleted cause of death (Item	tur é s	coner		'					

DHMH 17 Rev 1/2001

08-02698 Emily Burke		Please Typ Sta 1- For State Registrar			id / Depa		t of H	ealth and			giene	gible	20	0 8	3 1143
Physicia	ın/	1. Decedent's Name (First, Middl		D 1						2	Date of Dea		Year	3	. Time of Death
Medical Exami	ner	Emily Marga 4a. Facility Name (if not institution		Burke			I ab a	City, Town, or	Location of		April 5, 20	008	c. County of D)eath	2335 hrs
Ţ		4328 Louisville Road	n, give str	eet and numi	ber)			inksburg	Location of	Death			Carroll	Journ .	
Funeral		5. Social Security Number	6. Sex	7.	. Age (In yrs. Ia	ast birthda	_	f Under 1 Yea		_	8. Date of Bi	rth (MM	/DD/YYYY) 9	Birth	place (State or
Director		218-37-8179	1M	2X F	15		Yrs.	Months Days	Hours	Min.	Dec.	31,	1992 ^F	Coun	try) MD
yland a-f show any t once.	tor	Usual Residence of Decedent 10a. State 10b. County MD Carro 10e. Street and Number	11		10c. City, Syl	Town or kesvi	.11e	Of. Zip Code				10g. Cit	0d. Inside City Limits 1 Yes 2 No		
e Mar or 28	Director	1790 Miners Ri	dge I	rive				1784				USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral L	11. Marital Status 1 X Never Married 2 M	arried 1	. Was Deced Armed Ford	tent Ever in U. ces? 2 X No		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify: Wh.						etc.	n Indian, Black,	
rs afte ural",	à	3 Widowed 4 Div	or	es, Give Year Dates: ighest grade	completed)			Jsual Occupat		nd of wo	rk done	16b.	Kind of Busin		
136 thin 72 hou ne. than "nat	Completed	Elementary/Secondary (0-12)		College (1-4				of working life				е	ducati	on	
5-00 led wii Hygier other															
121 d be fil lental I arked	Be	Paul A. Burk		5		405.1	4-iii A-	idress (Stree			Zukow		Nt. or Town	Ctata .	Zin Cada\
Shoul and M	ဥ	19a. Informant's Name/Relations Mr. & Mrs. Pau			arents)			iners							
e, N Land 2 Health item 3	İ	20a. Method of Disposition			20b. I		Disposition	n (Name of ce			Date		Location - Ci		
MOF Pages ent of nt: If		1 Burial 2 X Cremation 4 Donation 5 Other Sp		Removal fron	n State A1	1 Cou	inty	Cremat	ion 4	4-11	-08	Sy:	kesvil	1e,	MD
Balti permit. Departm Importa		21. Signature of Funeral Service	vicensee w	15 Me	00764		P.O.	e and Address Box 1	95 Syl	kesv	ille,	MD :	21784		Chape1
Physician		23a. Part I. Enter the disease, or failure. List only one cause		ions that cau	sed the death	. Do not e	nter the r	node of dying,	such as car	rdiac or r	espiratory ar	rest, sh	ock, or heart		Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	_	Itiple Injur to (or as a c	ries onsequence o	of):						_		\dashv	Death
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause													
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D, be exe sician	ggic	UNPENDED	_ AI	MENDED											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ıysician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Uni	ne 1	Live birt	nt at time of de	2	Fetal Other	death 3 (Specify)	Ectopic	pregnan	су	23	3d. Date of de Month	elivery Da	y Year
P.O. es that the signed by the detache	y Phy	Part II. Other significant condit	ions cor	ntributing to o	death but not r	esulting in	the unde	erlying cause	given in Par	t I.		_			e cause of death?
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al R ian: T ertifica etor, p	Be C	25. Was case referred to medica examiner?						26.Place	of Death (Check or	nly one)				
of Vital Recing Physician: The I After this certificate	P	1 ✓ Yes 2 No	Hosp	" "	patient 2		atient 3				Home 5		lence 6		Scene
sion of ttending I death. ctor: Afte		27. Manner of Death 1 Natural 5 Pend 2 Accident Inve	ding stigation	28a. Date of Apr 5, 200		2325 h		10	ry at Work? Yes 2 ✓ I	No P	assenger	auto	jury occurred fixed obje	ct col	
Divisior pital or Attend ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Couldete	d not be rmined	(Specify)	of Injury - At h	et	_			4	or Town, 328 Louisvi	State) Ile Roa	ad, Finksbu	rg, MI	
To the Hospital within 24 hours To the Funeral completely fille	Medical (29a. Certifier 1 Certifying Prone) 2 Medical Exa	miner: On	To the best of the basis of manner sta	of my knowled examination a ted.	lge, death and/or inve	occurred estigation	, in my opinior	n, death occ	ce, and d curred at	ue to the cau	e and p	lace, and due	to the	cause(s)
FSFS	ž	29b. Signature and title of certifier 1 XI As A Pell MC						29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) April 6, 2008			

10

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Tasha Greenberg MD.

31. Date filed (Month, Day, Year) APR 0 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend istem 169 per not 18878 Head the and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 8:08 P M 2va 2 mass JOW /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore oachman t0+ Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 Months Mary GN 215-98-023 Director .1965 0 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene.

n 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f sh notified altimore 1 ☐ Yes 2/☐ No Completed by Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or adical Examiner must be r 21133 Coachman Court 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 11 Very 15 Yes, Give Year or Dates: Black, White, etc Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced If item 27 is marked other than "natu or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired Care Giver Elementary/Secondary (0-12) College (1-4or 5+) Griver rivate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Washington ဥ ugnita 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zib Code) Windsor Ave Baltimore MD 212

Jame of Date 20c. Location - City or Town, State vanita Brown 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 22. Name and Address of Facility Vaugnn C. Oreene Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4905 York Ind Baltimore, Mil 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MIAN 785 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) LONI attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature d title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (22) CEVE Daire 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh /8784-9-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Holman 2008 /Medical 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner Inion Memoria altimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 4 - 29 - 1928 Birthplace (State or Foreign Country) **Funeral** Months 216-20-9930 1 M 2 F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 Yes 2 No "natural", or items 23a or 28a-f shedical Examiner must be notified IM Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 3030 MC Elderry Street

Marital Status

12. Was Decedent Ever in U.S.
Armed Forces? abe by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 2 should be filed within 72 hours after or and Mental Hygiene. is marked other than "natural", or iter 1 ☐ Yes 2 7 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 10 Specify. 3 DWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private omestic CED permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any in Jury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Tar ျှ 19a. Informant's Name/Relationship (Type. Print) achelle Griffin 1526 Edison Highway Baltimore, MD 2013
e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ ofemation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4.9.2008 Baltimore, Mi Cremation Services Greenmunt Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Vaughn C. Shoene SISI Baltimore National A'ke Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 lays Embolism Physician Due to (or as a consequence of): /Medical Examiner Cereboussula Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Kenal Failure and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40061180 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Share p.0. East University Parkney Baltimore, Maryland P. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 9 2008 Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland / De State of Maryland / De State	epartment of I Dertificate of			giene Reg. No.2008	3 11443
4	Physici /Medic		Decedent's Name (First, Middle, Last) EVELYN SPERANZA BASH			2. Date of Dea Month April	Day Year 7, 2008	3. Time of Death 10:45 P.M.
	Examin		4a. Facility Name (If not institution, give street and number) Holly Hill Manor		or Location of Death	1	4c. County of De	
	Funeral Director		5. Social Security Number 024-22-5370 Usual Residence of Decedent	Months Days		8. Date of Birt (Month, Day Feb. 7	h y, Year) , 1929 Ma	irthplace <i>(State or Foreign</i> Co <i>untry)</i> ssachusetts
IN LICE SHOUSD filed within 72 hours after death with the Maryland Hyglene. thysiene. there we no reserve the manual of the manual of the medical Examiner must be notified at ent, the Medical Examiner must be notified at	ral Director	10a. State 10b. County 10c. City, Town of	or Location OWSON 10f. Zip Code	21286		10g. Citizen of What (
EXILIMOTE, INSTYIANG ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Completed by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 No Decedent's Usual Occur Give kind of work done ife. DO NOT use retire	Specify:		Black, Wi	hite
and 217	ld be filed with ental Hygiene ked other tha ic event, the I	To Be Com	17. Father's Name (<i>First, Middle, Last</i>) Joseph Speranza		Non Promise Non Non Promise Non Non Non Non Non Non Non Non Non Non	ofit		
, mary	and 2 shou ealth and M n 27 is mar er traumati		19a. Informant's Name/Relationship (Type. Print) Marc Hartstein (son-in-law) 52	Mailing Address (Stree 26 Murdock	t and Number or Ru Road Bal	ural Route Numbe Ltimore,	er, City or Town, State Maryland	21212
saitimore	: Pages 1 tment of He tant: If iter		4 Donation 5 Other (Specify) Green M	Disposition (Name of crematory or other plate of Crematory or other plate of the crematory or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or other plate or o	tory 4-9	Date 9-08	20c. Location - City of Baltimore,	Marvland
Dal	permit Depar Impor any in		21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	22. Name and Addr Mitchell- 6500 York t enter the mode of dy	ess of Facility Wiedefeld Road Ba ing, such as cardiac	Funera Itimore or respiratory ar	l Home, Ind Maryland	21212 Approximate Interval Between Onset and Death
V	Physician /Medical Examiner parture is a second of the control of	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of conditions).):				Chock and South
.O. BOX 68/6U,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical E	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnant 5 □ Other (specify) _			23d. Date of o	Day Year
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JIVISION OF VITAL	tending Physiclan: eath. tor: After this certifica the funeral director, the	Certification: To Be Co	25. Was case referred to medical examiner? 1	me of ury M 1	her: 4 Nursing H ury at ork? Yes 2 No	28d. Describe I	dence 6 Other (S) now injury occurred	
2	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my	opinion, death occu	e, and due to the	cause(s) and manner date and place, and c	lue to the cause(s)
)	To To com	M	29b. Signature and title of certifier This Yould May M. (2) 30. Name and address of person who completed cause of death (Item 23a) (To	0. 057	454		29d. Date signed (Mo $04/08/$	onth, Day, Year)
	Sta Begistr		30. Name and address of person who completed cause of death (item 23a) (1.1 2.1 2.1 2.1 2.1 2.1 2.1 2.1 2.1 2.1	Lither	rille Mi	0 210	93	

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		For	State	of Marylar		artment of h			ental Hy	giene	0.0	1 1 1 1 1 1 . 1 .
		1 - State Registrar			Cei	rtificate of	Death			Reg. No. 🗸 U	00	
Physicia	an	Decedent's Name (First, Middle							2. Date of Dea	7 Day 2008	Year	3. Time of Death 3:30AM M
/Medic		Margaret E1 4a. Facility Name (If not institution			зтеу	4b. City, Town, o	or Location		April	4c. County		3:30AM
Examin	er	Long View N	. 0	,		Manch					Carr	011
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		24 Hrs.	8. Date of Birt	th v. Year)		place (State or Foreign ntry)
Director		215-18-6691	1□M 2∏F	85	Yrs.	Months Days	Tiodis	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	March .	y, Year) 30,1923		MD
and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					1	10d. Inside City Limits
Maryl f sho	ξ	MD Bal	timore		Reis	terstown						1 ☐ Yes 2 No
If it is not safer death with the Maryland flied within 72 hours after death with the Maryland Hygiene. Hygiene, there than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Director	10e. Street and Number	. CIMOIC		TO TO	10f. Zip Code				10g. Citizen of \	What Cou	ntry?
th witi 23a o Ist be	alD	301 Cantata C	ourt			21	136			Ţ	JSA	
r dea tems er mu	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Or Dan, Mexica	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Blac	e - Americ ck, White,	ean Indian, etc.
s afte	by Fi	1 ☐ Never Married 2 ☐ Marr 31 ☑ Widowed 4 ☐ Divorced	if Yes. G	2 X No ive Dates:		1 ☐ Yes 2 No	Specify:			Specify	y: T.TL	ito
tural sal Ex		21	t's Education	Dates.		dent's Usual Occup				16b. Kind of B		ite dustry
hin 72 an "ng Medic	plet	(Specify only higher Elementary/Secondary (0-12)	1	(1-4or 5+)	(Give	kind of work done DO NOT use retire	during mos d)	st of worki	ing			
ad with	Completed	9			Н	ousewife					n Hom	e
be file tal Hy d oth	Be	17. Father's Name (First, Middle,							•	Maiden Surnan	ne)	
y and hould a Men narke natic	은	William Oliver			405 14-75				th Mai		01-1-7	0.41
parmit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Important: If them 27 Is marked other than "natural!", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations		1		ng Address (Street					State, Zij	o Code)
Heal Heal tem 2		Carol L. Baldw 20a. Method of Disposition	in dai	ighter 20b. I	Place of Dispo	ailroad A	1		oate M	D 210/1 20c. Location -	- City or T	own, State
ages ent of tt: If if		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	-	matory or other pla Forest V		m //	/10/08	Orrina	- M-11	ls, MD
mit. F partmo oortar Injur		21. Signature of Funeral Service		7		2. Name and Addre						own Road
g a m g g		Stepher	M.	Lenk	Eus E	line Fun	eral I	Home		sterstov		
1		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea	th. Do not en	ter the mode of dyi	ng, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between
Physician	10 4	Immediate Cause (Final disease or condition	a	End -	stoge	2 advo	ince	Lo	lemen	tu		Onset and Death
/Medical Examiner		resulting in death)	Due to	o (or as a consec	quence of							
Examine	<u></u>	Sequentially list conditions,	b	o (or as a consec	ruence of).							
Nsit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	((0. 40 4 00.000	440.100 01/1							
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To the Hospital or Attending Physician: The law requires that the death certificate be executed virtin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunial-transit.	dical		d									
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leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf pregn birth 2 ☐ Feta	al death 3	Ectopic pregnanc	у				ite of deliv	ery Day Year
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uires uires la signa la be	d by	There	id no	dules	- ,				10	Yes 20 No	3 🗆 Pro	bably 4 □Unknown
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ding Physician: The Information After this certificate he funeral director, page	To E	examiner? 1	Hospital: 1	Inpatient 2] ER/Outpatie	nt 3□ DOA Oti	her: 4 N	ursing Ho	me 5 Resi	dence 6 □Oth	ner (Speci	fy)
ing P		27. Manner of Death 1X Natural 5 ☐ Pendin		e of Injury onth, Day Year)	28b. Time o Injury	Wo			28d. Describe	how injury occur	red	
ttend feath. ttor: /	cati	2 Accident investig	not be	o of injuny . At h	ome form et	M 1	Yes 2		20f Location (Ctreet and Numi	har ar Bu	al Paulo Number
or A after of Direction by	Certification:	4 ☐ Homicide determ	nined 200. Flac	ding, etc. (Speci	ify)	eet, factory, office		,	City or Tol	wn, State)	ber or mur	al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		29a. Certifier 1 Certifyir	ng Physician: To th	ne best of my kn	owledge, deal	th occurred at the t	ime, date a	nd place,	and due to the	cause(s) and m	anner as s	stated.
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5		29b. Signature and title of certifie 30. Name and address of person 41 75 - A 31. Date filed (Month, Day, Year) APR 0 9 20	Who completed car	use of death (Item	m 23a) (Type,	Print)	ter	/	4D. 0	21102		
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State Registrar DHMH 17 Rev 1/2001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	arylan		artmen			and N	lental Hy	/giene Reg. No.	20	0 8	
-	Physic	ian	1. Decedent's Name (First, Middle, La	E.							2. Date of De	eath Day	,	Year	3. Time of Death
	/Med	ical	EVELYN				BANKS				APRIL	. 6	200)8	10:54P ^M
	Exami	ner	4a. Facility Name (If not institution, gi NORTHWEST HOSP]				4b. City,	,	Location of	of Death			County of		
	Funeral		5. Social Security Number 6.	Sex . 7. Ag		last birthday)	If Under	1 Year	If Under		8. Date of Bi		ALTIN		ace (State or Foreign
п	Director		216-18-6137	1□M 2ØF	85	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D 09/11/	1922		Coun	lace (State or Foreign stry) MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	nation							14.	0.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1
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	rs after death with the Marylan I", or Items 23a or 28a-f show		507 RIDGE ROAD					2104	-8				US/		
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							0-			an Indian,
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🗖 Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 □1 If Yes, Give Year or Dates:	No 1 □Yes 2 XNo Specify:								Specify:	White, e	
9	72 hours aff "natural", or idical Exemi	ted t	15. Decedent's F	ducation	- 11	16a. Dece	dent's Usua	Occupa	ation			16h Kir			
215	hin 72 e. an "na Media	plet	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5	-1)	(Give life. L	kind of word OO NOT use	k done d e retired)	uring most)	of work	ing 16b. Kind of Business/Indu			iustry	
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and	~ = 0 9	o o	17. Father's Name (First, Middle, Last								e (First, Middle	, Maiden s			
Maryland 21215-0036	should be and Mental s marked o	2	FRANK 19a. Informant's Name/Relationship		CHMO)SE_			CARF		
	nd 2 s llth an 27 is i		SUSAN DUNN / DAU			19b. Mailin	RIDGE	Street a ROA	nd Numbe D. FI	r or Run NKSI	al Route Numb BURG, M	per, City or	Town, Si L048	tate, Zip	Code)
Ē,	s 1 ar of Hea Item	-	20a. Method of Disposition		20b. P	lace of Disposemetery, cren					Date		ation - Ci	ity or To	wn, State
<u>m</u>	permit. Pages 1 and 2 should be Department of Health and Mente Important; If Item 27 is marked any Injury or other traumatic es once.		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Ponation 5 ☐ Other (Specia			I ISRA				04/08	3/2008	BAL ⁻	LIMOR	RE. I	MD
Baltimore,	epartr epartr porta ny Inju		21. Sgrature of Funeral Service Ace	nsee			. Name and		s of Facility	/ S(L LEVÍ	NSON	& BF	ROS.	, INC.
	20E#3		Michael	Druge	1					OWN	ROAD -	PIKE	ESVIL	LE,	MD 21208
			23. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final												Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		SEP	505								Onset and Death
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8760,	cate be executed physician and the burial-transit	dical		d											
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Vital Records,	ding Physician: The law requii n, After this certificate has been s funeral director, page 2 should	Completed by	CENEWAMY ANTE	ry DISET	SE	· 10€	nipt,	FENT A			24a. Was		24b. We	re autop	osy findings available of
alF	r: The icate r, pag			ASE!	17	RIAL	FIBR	1/4	tion		perfo 1 ☐ Yes	rmed? 2 M No	dea	ath?	2 X No
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of	g Physer this eral di	٦: <u>۲</u>	1 Yes 2 No 27. Manner of Death	1 Inpatier 28a. Date of Injur		R/Outpatient 28b. Time of			4 L.J 14u1		ne 5 ☐ Reside 128d. Describe I			(Specify)
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Division of	r Atte er deg recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	ry - At hon	me, farm, stre	et, factory, o	office		- 2	28f. Location (S	Street and	Number	or Rural	Route Number,
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	Hosp 24 hou Fune tely fil	ical	29a. Certifier 1 XCertifying Ph (Check only one) 2 Medical Exam	ysician: To the best o	examınatı	vledge, death ion and/or inv	occurred a estigation, i	t the time	e, date and inion, deatl	place, a	and due to the	cause(s)	and mann	ner as st	ated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (
	F ≯ F ŏ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (RIADE B. COLANAN AND) 31. Date filed (Month. Day, Year) 32. Registrar's Signature												
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	.4		CREADO B.	CONTON		u)		\S'	HELLA	1150	ENLI	NIL	246	ND	21133
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 ear APRIL 7:27P DAVID LEF **BORTZ** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 725 MT. WILSON LANE, #507 PIKESVILLE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F Months Days Hours Min 218-54-4126 Director 54 06/10/1953 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Framiner must be retified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 BRICKSTON ROAD 21136 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No WHITE Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) LAWYER LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ABE BORTZ RITA GRADSKY 2 permit. Pages 1 and 2 should Department of Health and Mi Important: If item 27 is mark any injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JON BORTZ / BROTHER 8805 SLEEPY HOLLOW LANE, POTOMAC, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 04/08/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature on Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-transit and Due to (or as a consequence of): ed by the attending physician a detached for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) I ☐ Yes 2 ☐ No signed by the 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by YPERLIPIDEMIA 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? 1 Yes 2 No 2 □No 1 Tyes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) RESIDENCE PARENTS Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending To the Hospital or within 24 hours after death.

To the Funeral Director: Af Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

31. Date filed (Month, Day, Year) State APR 09 Registrar

ARTHUR

(Check only one)

29b. Signature and title of certifie



ATTENDING PHYSICIAN

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PUDO,

2008

WESTMWSTER

29d. Date signed (Month, Day, Year)

29c. License number

21155

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wich I MD. April 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 301 Hospital Drive, Glen Burnie, MD, 20161 egistrar's Signature State Registrar

29a. Certifier

(Check only one)

ca

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per me 98/8 4-9-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vear PM 3:20 Adril 2008 /Medical rances 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai City Baltimore Hospital OC Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 499-/6-9933 Usual Residence of Decedent 1 ☐ M 2 🕦 F Director irginia with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shot Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 UNO **Funeral Director** Baltimore Windsor 10e. Street and Number 10f. Zíp Code 10g. Citizen of What Country? apt U.S.A. 21244 ZB 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liury or other traumatic event once. Be 1seltran 2 Hollana 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) ichmond Black 4100 20a. Method/of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Kidge (em 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-12-2008 Funeral Service P.A. 21. Signature of Funeral Service Licensee 22. Name, and Address of Facility Carlton C Loughes 1701 Mc Culloh St. Nan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Subdural Hematoma Days /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): tracture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed Pulmonary 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an After this certificate has autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 21 2008 UNKNOWN 1 ☐ Yes 2 X No 2 Accident 03 Fall 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Street within 24 hours after death To the Funeral Director; 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Street 4014 Park Heights Avenue 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD AU4176435T15803 2008 April 5, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Tully Sinai MD Hospital Baltimore 1. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Frances Blac

Physician /Medical Examiner and The law requires that the death certificate be exec Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Certification:

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attending physician signed by the certificate this After Director;

Hospital or Attending Physician:

within 24 hours a To the Funeral I

23b. Was decedent pregnant

5 Pending investigation 6 ☐ Could not be

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

29b. Signature and title of certifier

APR 0 9 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zu Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

1 ch M.C U

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29d. Date signed (Month, Day, Year) 2018

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P MEHTA. 7601 OSLER DRIVE M. D. TOWSON, MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Dav Month **Physician** A VANS NAMBER /Medical 6 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NOTTh Wes Timory
ear | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Days Hours 20-20-328 Months 1**∑**′M 2□ F Director June 13,1929 m. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 √Yes 2 □ No Director MD. BAITIMORE 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 3412 WAShingTon 21246 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 17 Yes 2 No 17 Yes, Give Year or Dates: Kore And 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: BlACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PostA / Services MAINTENCE eTIREd is marked other 17. Father's Name (First, Middle, Last), 18. Mother's Name (First, Middle, Maiden Surname) Be hambers ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Washington Thambers LOdiA BATTIMORE MI Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2 (KENINGS M:115 MD) 21 Signature of Fundial Service Licensee 22. Name and Add ss of Facility -unera CARBINEST, BA 2/2/2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Peritorules /Medical te to (or as a consequence of): Examiner Due to [s] as a consequence of: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Toxic mesacelon

Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tyes No 3 Probably 4 Unknown Completed grand mal seizure disorder 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 228628 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Elxtm, mD 21921 N. Bridge 31. Date filed (Month, Day, Year) 32. Relistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

APR 09

			For State Registrar		State of	Marylan		artment of F ctificate of			giene Reg. No. 2	108	111.51	
			Decedent's Name	(First, Middle,	Last)					2. Date of Dea	ath	3. Time of Death		
3	Physici: /Medic		Leonard 1	N Clark						April	4, 2008 2:00 PM			
)	Examin		4a. Facility Name (If I			,		4b. City, Town, o	r Location of Death			ly of Death		
-	A report of the second				ng Center		la a t la luita da . ()	If Under 1 Year	Silver S	r Spring Montgomery 4 Hrs. 8. Date of Birth 9. Birthplace (Sta				
L	Funeral Director		5. Social Security Nu 577-16-92	215	5. Sex 7 1 M 2 □ F	. Age (In yrs.	Yrs.	Months Days	Hours Min.	/ 1919	9. Birthplace (State or Foreign VA)			
	ryland how at		Usual Residence of I 10a. State	10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
	e Ma Ba-f s	Director	MD	Montg	omery	Si	lver S	pring					1 ☐ Yes 2 🛣 No	
	vith th	Dire	10e. Street and Num					10f. Zip Code			10g. Citizen of Unite	of What Country?		
	eath v	Funeral	8505 Spr:	ingvale	Road #2		S 13 1	20910-		pacify Vas or No.			can Indian,	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fun	1 □ Never Marrie		Armed Ford	es? :□No		f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ack, White	, etc.	
Ş	2 hou atura cal E	led l		15. Decedent's	Education	SS. AA AA TI	16a. Decedent's Usual Occupation				16b. Kind of I	Business/Ir	ndustry	
215-0036	hin 73 an "n Medi	Completed	(Specif		grade completed) College (1-4	College (1-4or 5+)			during most of worl ਹੈ)	king	Baked	Good	ls	
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Maryland	d be fill ed oth ed oth	B	17. Father's Name (F		ast)				18. Mother's Nam Mamie		Maiden Surna	ime)		
ary	shoulk ind Me s mark umatic	입	19a. Informant's Nar		o (Type. Print)		19b. Mailir	g Address (Street	and Number or Ru	ral Route Numbe	er, City or Town	n, State, Zi	ip Code)	
Ĕ	and 2 salth a n 27 ls er trai		Wendy Bl	um/Frie	nd		1669	9 Columbi	a Road N	w #106 v	Vashing	ton,	DC 20009-	
Baitimore,	Pages 1 and of He	ļ	20a. Method of Dispo 1 ☐ Burial 2 ☑ 4 ☐ Donation	Cremation 3	B □Removal from St	ate c	emetery, crer	sition (Name of natory or other place ake Crema	i	Apr 7 2008	20c. Location Belts		own, State Maryland	
Balt	permit. Pages 1 Department of H Important; If ite any injury or ott		21. Signature of Fun	1 (X 4/1)	gensee	M003	82 22	Name and Addre Rapp Fune: 933 Gist	ss of Facility ral & Cren Ave. Silv	nation Se ver Sprin	rvices g. Marv	land	20910-	
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	/Medical		resulting in death)	4		as a consequ		DATAL] /EAR	
	Examiner		Sequentially list cond	ditions.	b		RTEN	SION						
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≫,0q/gc	ificate be executed physician and st the burial-transit	edical E			d.									
P.O. BOX	w requires that the death certi been signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outco 1 □Live bir 4 □ Pregnal 9 □ Unknow	Ideath 3	Ectopic pregnancy Other (specify)	/		23d. Date of delivery Month Day Yea				
7	s that ned b	by Pr	Part II. Other signific	eant condition	s contributing to dea	th but not resu	ulting in the ur	derlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to	the cause of death?	
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<u> </u>	The law ate has b page 2 sl	Son								autop perfo	med? 2 No	death?	2 □ No	
7113	ician; sertific ector,	Be (25. Was case referre examiner?		Llagarital			l au	26. Place of Deat					
0	Phys this c	6	1 ☐ Yes 2 N 27. Manger of Death	lo	Hospital: 1 Inp		ER/Outpatien 28b. Time of	t 3 DOA Oth	er: Nursing Ho	ome 5 Resid	lence 6 🗆 Ot	her (Speci	ify)	
VISION OI	ding h. After funer	tion	1 Natural 2 Accident	5 ☐ Pending investigat	(Month,	Day Year)	Injury	Worl	yat k? Yes 2□No	28d. Describe h	ow injury occu	irrea		
S	Atter r dear ector	fica	3 ☐ Suicide	6 Could no	t be 28e. Place o	injury - At ho	me, farm, stre	eet, factory, office				ber or Rur	ral Route Number,	
5	s arte al Dir	Certification:	4 🗌 Homicide		building	, etc. (Specif)	/)			City or Tow	n, State)			
	To the Hospital or Attending Physician: The law within 24 bours after death, within 24 bours after death, To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 and page 2.	Medical (29a. Certifier (Check only one)	Certifying	Physician: To the bas aminer: On the bas and manne	is of examina	wledge, death tion and/or in	occurred at the tir restigation, in my o	ne, date and place, pinion, death occu	and due to the great at the time,	cause(s) and n date and place	nanner as :	stated. to the cause(s)	
	To t. Withi To tl	Ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo										, Day, Year)	
			Renss					D 28	656		APRIL	7	2008	
	lot1		30. Name and address		no completed cause	of death (Item	23a) (Type,	Print)	+2.0 D	<i>a</i> , <i>1</i> · <i>1</i> · · ·	- 111	5 -	0 5 6	
	Sta	6	RAVI YA 31. Date filed (Month		32 Rec	istrar's Signa	ture	CVEKD	7208 RO	CKVILL	= IVID	20.	850	
	Registra			R 0 9 2	008	wes fil	ture	the same						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month -2008 Laurence M. Conley 110 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of 4c. County of Death Examiner +OMS VI timore NWO 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 2, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 T F Months Hours Min Director 332-28-5362 86 Feb. 1922 Ohio Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐Yes 2X No Maryland Baltimore Catonsville the ! 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? with 1 or be 21228 USA r than "natural", or Items 23a the Medical Examiner must b 719 Maiden Choice Lane BRT19 death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 MAYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify à 3K Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Maguire Clyde Earl Conley traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace 101 Melvin Avenue; Catonsville, MD 21228 Gerald Conley Son injury or other Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/7/2008 Catonsville, Maryland Crematory Metro 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Lice Funeral Home of Catons 1630 Edmondson Avenue; 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Months Immediate Cause (Final disease or condition resulting in death) Metastatic Squamous Cell Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresquence of) executed Exami burial-tran Due to (or as a consequence of): Box 68760, attending physician pe Physician/Medical the as nse s IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a d be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? Yes 2 No this certificate Division or Vital 1□ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 (C) Ne 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: or Attending After 5 Pending investigation within 24 hours after uses...

To the Funeral Director: Aft 1 Yes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical

6×1

State Registrar 29b. Signature and title of certifie

31. Date filed (Mo

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

Maiden

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

tone

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year OPHELIA COUPLING SEDONIA 22 21 M APR 2018 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOWARD HOWARD (OUNTY HOSPITAL GEN CCLUM BIA 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 M 2XX Director 88 MARYLAND 214-24-2575 AUG 1919 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND BALTIMORE CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ns 23a r death v Funeral 11617 EASTERN AVENUE 21220 U.S.A. r than "natural", or items the Medical Examiner me Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CO BOARD CUSTODIAL ENGINEER 12th grade OF EDUCATION traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h 1 and 2 should be JAMES H. VENEY ပ RINGOLIA SCOTT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau Harriette J. McDuffie/Daughter 8750 MARY LANE, JESSUP, MARYLAND 20794 laltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS MEMORIAL 04-12-08 MIDDLE RIVER, MARYLAND 21. Signature of Fune WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part / Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, long, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death HNOXIC ENCEPHALO DA TITY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ESRD & Sequentially list conditions Due to (or se a consequence of, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit Throanboomfolds a Verenous and Due to (or as a consequence of) physician a TIME Physician/Medical ASTIR INTESTINAL BLEEDING IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 ☐Ectopic pregnancy 4☐Pregnant at time of death Month Dav Year 5 Other (specify) 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Carclence 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy perform 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ျ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Man of Death After t 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation (Month, Day Year) 1 Yes 2 No 2 Accident

Box 68760 P.0

Division or Vital Records,

or Attending F after death. 24 hours after death e Funeral Director: Hospital

State Registrar

DHMH 17 Rev 1/2001

the

LKECHAKWIN 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

6 Could not be determined

32_Registrar's Signature

MEDUNU

30. Name and addréss of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00056949

a struct.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

COUNTY GEN

29d. Date signed (Month, Day, Year)

2008

THIS POTAL CREAMA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

08-02699
Rudolfo Calderon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

dudono Garderon	J	I- For State Registrar	Ce	rtificate of De		no Mentai F	_	2 (eg. No.	108 1145		
Physicia Medical Examin	-	1. Decedent's Name (First, Middle,Last) Rodolfo Calderon					2. Date of Deat	Dav Year	3. Time of Death 2335 hrs		
*gka		4a. Facility Name (if not institution, give stre	et and number)	4b. C	ity, Town,	or Location of Deat	April 5, 20	4c. County of			
		4328 Louisville Road 5. Social Security Number 6. Sex	T7 A - //		nksburg		To no const	Carroll	District Co.		
Funeral Director		612-66-6717 _{1_M}	7. Age (In yrs. 14		Under 1 Ye	ear If Under 24Hr ays Hours Min		21 1993	9. Birthplace (State or Foreign Country) CA		
any	ł	Usual Residence of Decedent 10a. State 10b. County		Town or Location					10d. Inside City Limits		
land f show	į	MD Carroll	F'i	inksburg					1 Yes 2 X No		
death with the Maryland or items 23a or 28a-f show must be notified at once.	Dire	10e. Street and Number 4174 Louisville		2	. Zip Code .1048		10	Og. Citizen of What	: Country?		
₽	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced or Driver or Driver Marital Status	Was Decedent Ever in U Armed Forces? Yes 2 X No s, Give Year	If Yes, s	pecify Cub	Hispanic Origin?(S an, Mexican, Puert No specify: Mex	o Rican, etc.)	White,	American Indian, Black, etc. white		
hours 'natur Exami		15. Decedent's Education (Specify only high	hest grade completed)	16a. Decedent's Us during most o		eation (Give kind of fe. DO NOT use re		16b. Kind of Busin	ness/Industry		
5-0036 led within 72 Hygiene. other than '	Completed	9	College (1-4 or 5+)	stu	dent			educati	on		
21215-0036 Muld be filed within 7 Mental Hygiene anarked other than re event, the Mediza	Be	17. Father's Name (First, Middle, Last) Roberto Calderon				18.Mother's Nam Maria S		Maiden Surname)			
MD 21 nd 2 should with and Me m 27 is ma aumatic ev	٩	19a. Informant's Name/Relationship (Type, Mr. & Mrs. Roberto (Print) parents Calueron	. 17				nber, City or Town,			
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other thingury or other traumatic event, the Med		20a. Method of Disposition 1 XBurial 2 Cremation 3 R 4 Donation 5 Other Specify:			ace) meter	-y 4-1	Date 1-08	Reister	stown, State		
Balt permit. Departi Importi		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home P.O. Box 195 Sykesville, MD 21784									
Physician /Medical		23a. Part I. Enter the disease, or complication failure. List only one cause on each lin	ons that caused the death e.								
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):									
	힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	o (or as a consequence o	ıf):							
ist g dy	Exam	(Disease or injury that initiated events resulting in death) Last	o (or as a consequence o	f):							
760, cate be executed physician and he burial - transi	edical	d. UNPENDED AM	ENDED								
8760, tificate be ex ng physician as the burial	5 I	3b. Was decedent pregnant in the	c. If yes, outcome of preg	nancy 2 Fetal de	eath 3	B Ectopic pregr	ancy	23d. Date of de	elivery Day Year		
Box 687 he death certific	iysician/I	past 12 months? 1 Yes 2 No 9 Unknown 9	Pregnant at time of de								
ires that the de signed by the	음	Part II. Other significant conditions cont	ributing to death but not r	esulting in the under	lying cause	e given in Part I.		bacco use contribu	te to the cause of death? Probably 4 Unknown		
Division of Vital Records, tal or Attending Physician: The law require as after death. al Director: After this certificate has been si led in by the funeral director, page 2 should be.	Completed						24a. Was a	an 24b. We	ere autopsy findings available or to completion of cause of		
Reco The law cate has	E O							med? dea	ath? Yes 2 No		
tal Recician: The	e n	25. Was case referred to medical examiner?	al:		_	Ce of Death (Check					
n of Viiing Physical After this	<u> </u>	1 ✓ Yes 2 No 27. Manner of Death	8a. Date of Injury	ER/Outpatient 3 28b. Time of Injury	DOA 28c, In	jury at Work?		Residence 6 🗸			
ttendin tendin feath. ttor: A / the fun	ation	1 Natural 5 Pending 2 Accident Investigation	Apr 5, 2008	2325 hrs	1	Yes 2 V No	Passenger a	auto fixed obje	ct collision		
Divis	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Run or Town, State) 4 Homicide (Specify) Local Street 4328 Louisville Road, Finksburg, MI									
	293. Certiffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 293. Certiffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	Ĕ	29b. Signature and title of certifier	el nes			nse number		29d. Date signed April 6, 2008	(Month, Day, Year)		
	-	30. Name and address of person who compl		ı 23a)	5.0						
2		Tasha Greenberg MD. Assis	stant Medical Exam	iner 111 Pen	n Street	, Baltimore, M	D 21201		-·		
Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ire							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** Month Joyce Sue Chew 2008 5:30 A. Apri1 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Caton Manor Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 09/24/1931 9. Birthplace (State or Foreign Country)
China 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🕅 F Director 217 54 2328 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at N/A 1X Yes 2 No Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2757 Marbourne Avenue Funeral 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after dual Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 No 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other teamers. Self-Employed Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bing Woo ဥ FongKee Dong 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Chew / Daughter 2757 Marbourne Avenue Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 04/09/2008 | Glen Burnie, Maryland 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licens 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the booth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Aspiration disease or condition resulting in death) PRobable /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit certificate be exec Due to (or as a consequence of). P.O. Box 68760. attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No the 9□Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 2X No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2**X** No 1 ☐ Yes P 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifie

MATEGN

AW AN 10802 32. Registrar's Signature 2008

and manner stated.

MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D0062634

29d. Date signed (Month, Day, Year)

2608

04/08/

COLUMBIA MA

08-02697	
Maria Catalfamo	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

viaria Catalianio	1- For State State of Maryland / Department of F)ooth	g. No. 2008 1145		
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	2. Date of Death	Day Year 2204 has		
Medical Examiner	- CHILITIES THE	City, Town, or Location of Death	4c. County of Death		
	Johns Hopkins Bayview Medical Center Baltimore N/A				
Funeral Director	218-58-3944 1_M 2\[XF \] 55 Yrs.	If Under 1 Year If Under 24Hrs. 8. Date of Birt Months Days Hours Min. 12/14	h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD		
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits		
	MD N/A BALTI		1 X Yes 2 No		
Maryla Maryla dat or recto	10e. Street and Number	Of. Zip Code	0g. Citizen of What Country?		
ith the 23a or notific	629 S. BELNORD AVENUE 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I	21224 Decedent of Hispanic Origin? (Specify Yes or No-	U.S.A.		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? If Yes 1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Y	specify Cuban, Mexican, Puerto Rican, etc.)	White, etc. Specify: WHITE		
hours aft natural" Examine	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's during mos	Usual Occupation (Give kind of work done tof working life, DO NOT use retired)	16b. Kind of Business/Industry		
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 AID	ר	PAROCHIAL SCHOOL		
5-00 ed with tygiene other o	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, M			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO Be Comple	CHARLES CATALFAMO	JOSEPHINE ddress (Street and Number or Rural Route Num	SCILIPOTI		
ID 21 2 should and Me 27 is ma matic ev	11.21	HEPHARD COURT, BEL A			
e, N I and J Health Titem ?	20a. Method of Disposition 20b. Place of Disposition	on (Name of cemetery, Date	20c. Location - City or Town, State		
Pages Pages nent of ant: Il	4 Donation 5 Other Specify: QAK LAWN	CEMETERY 4/10/08	BALTIMORE, MARYLAND		
Baltimore, MD permit. Pages I and 2 sht Department of Health and Important: If item 27 is injury or other traument	21. Signature of Funeral Service Licensee	re and Address of Facility CTY EASTERN AVENUE, I	FUNERAL HOME BALTIMORE, MD 21231		
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the		est, shock, or heart Approximate Interval		
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic cardiovascular disease Death				
xammer	or condition resulting in death) Due to (or as a consequence of):				
ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
red nsit Examíner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ecuted and and all all all by	<u> </u>				
760, rate be execut physician and he burial - tra	X UNPENDED #MSN.77, perME, g879, 5/8/08	TT	23d. Date of delivery		
6876 ertificat ding ph e as the	Z3d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year				
). Box 687 the death certific yy the attending p ched for use as the	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Othe	r (Specify)			
O. E lat the d by the etached			obacco use contribute to the cause of death?		
S, P.(1Yes	an 24b. Were autopsy findings available		
Records, The law require, frate has been sig., page 2 should b. Completed		autop			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	25. Was case referred to medical	1 ✓ Yes 26.Place of Death (Check only one)	2 No 1 Yes 2 No		
Vital ysician ysician director	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient		Residence 6 Other:		
ing Phy After th funeral	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		how injury occurred		
Sior Attend r death ector: by the	2 Accident Investigation 28e Place of Injury - At home farm street	1 Yes 2 No factory office building etc. 28f. Location (Street and Number or Rural Route Number, City		
Division o spital or Attending tours after death. neral Director: Afte filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, S			
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	Pomicide 29a. Certifier (Check only one) 29a. Certifier (Check only one) 2 w Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 39a. Certifier (Check only one) 2 w Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
A S S S S S S S S S S S S S S S S S S S	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)		
	my m, m,	O.C.M.E.	April 6, 2008		
(5)		Baltimore, MD 21201			
State Registra	1 DD - 0000 14.	p.			
DFIME 17 Rev 1/2001	ORIGINAL	e1	OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month Douglas Vaughan Croker, Jr. April 5, 9:30 P M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Blakehurst Towson Baltimore 8. Date of Birth (Month, Day, Year)
Dec. 17, 1927 6. Sex 1 XM 2 ☐ F If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Min. Months | Days Hours 216-20-1364 80 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore 1 ☐ Yes 2(XNo Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Road 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Vaughan Croker, Sr. Margaret Herbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas V. Croker, III (son) 27588 Wakefield Lane, Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Hilltop Svc. Corp. 04/08/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat ve of Fund 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause or each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Orset and Death Immediate Cause (Final mo disease or condition resulting in death) Due to (or as a consequence of) Due to for es a consecuence off Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

death

72 hours after

filed within 7 I Hygiene. other than "r

s 1 and 2 should be fil Health and Mental H tem 27 is marked ott

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trausone.

3altimore, Maryland 21215-0036

P.O. Box 68760

or Vital Records,

Division

Physiclan:

after

within 24 hours a

To the Funeral C To the Hospital

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death certificate be

r 28a-f show notified at

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be

Director

Funeral

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Completed

Examiner þ

use as the burial-transit attending physician Physician/Medical for ed by the a detached f signed by d Completed certificate 은 After this funeral Certification: death. To the Funeral Director: /

Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9☐Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 2X No 3 ☐ Probably 4 ☐ Unknown

1□ Yes 26. Place of Death (Check only one)

N Charlest, Baltimore In

24a. Was an

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Day

Year

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation

determined

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at Work? 1 Tyes 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 Thomicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Other:

29d. Date signed (Month, Day, Year)

State

Registrar

Medical

DHMH 17 Rev 1/2001

Registrar

1041

M.D.

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEHTA,

2008

JOGINDER P.

31. Date filed (Month, Day, Year) APR 0 9

OSLER DRIVE

TOWSON, MARYLAND 21204

7601

Registrar

DHMIT Rev 1/2001

OCME 2006

31. Date filed (Month, Day, Year) 32 Registrar's Signature APR 0 9 2008

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ling Li, MD

hi

and manner stated

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** William Eugene Dick 2008 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 11**∑** M 2 □ F 215-24-4719 78 Director Nov 29 1929 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. n 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a, State MD r 28a-f sh notified Carrol1 Sykesville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1599 Homeland Drive Unit 3E 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No It Yes, Give Year or Dates: 1 Never Married 2 Married Korea 3altimore, Maryland 21215-0036 1□Yes 2√□No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) finance financial manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Jesse Dick B. Jeanette Dick 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health an Important: If then 27 Is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Helen Dick (spouse) 1599 Homeland Dr. Unit 3E, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Garrison Forest Vet. UNK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee aid Housest P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter he disease, or complications shock, or heart failure. List only one caus causes the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine

Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy

3. Time of Death

5:15a

Birthplace (State or Foreign Country)

white

10d. Inside City Limits

Approximate Interval Between Inset and Death

23d. Date of delivery

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of

Year

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No

24a. Was an

1 ☐ Yes 2 No

been signed by the attending physician and should be detached for use as the burial-tran

Division or Vital Records, P.O. Box 68760,

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To the Hospital o within 24 hours aft To the Funeral Di

Completed Certification:

Physician/Medical

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Be

ို

Medical

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 ☐ Other (specify)
eart II. Other significant conditions	s contributing to death but not resulting in t	he underlying cause given in Part I
25. Was case referred to medical		26. Place
examiner?	Hospital:	estient 3D DOA Other:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		performed death? 1 Yes 2 No 1 Yes 2 No			
25. Was case referred to medical examiner?	26. Place of Death (Check only one)				
examiller: 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home 5 Residence 6 Dother (Specify) DOVE LOUS			
27. Mannerof Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury N	Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No			
3□ Suicide 6□ Could not b 4□ Homicide determined	28e. Place of injury - At home, farm, street, factory, offi building, etc. (Specify)	ice 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death occurred at th niner: On the basis of examination and/or investigation, in n and manner stated.	ne time, date and place, and due to the cause(s) and manner as stated. my opinion, death occurred at the time, date and place, and due to the cause(s)			
29b. Signature and title of certifier	1/ 29c. Ljo	ense number 29d. Date signed (Month, Day, Year)			

10

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 1700 PPR Mary Ann Diehl 300% /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Margland 130 Itimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** Days Hours Months 1 □ M 2 🛛 F 201-22-0008 Pennsylvania Director April 16,1930 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director Maryland Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 14. Race - A 8419 Tally Ho Road 21093 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 5 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Consultant <u>Department Store</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Louis J. Honoski Helen Perzyna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George S. Diehl, Jr. Husband 8419 Tally Ho Road Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4□Donation Hilltop Service Corp. 4-7-2008 Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral 21. Signature of Puneral Se vi Licensee Home Inc. 21204 1050 York Road Towson, Maryland a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician days Lemi /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner he law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O, Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 22 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, p.ge 2 perform 1 ☐ Yes 2 ☐ No 1□ Yes 2☑No Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a TS certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier ical (Check only one) and manner stated. 29c. License number

within 2

State Registrar

31. Date filed (Month, Day, Year) APR 09 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29d. Date signed (Month, Day, Year)

April 3, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) O₅ APRIL **Physician** DWARDS 655 MAUDIE 2008 /Medical 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GOOD SAMARITAN HOSPITAL MD PALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 238145692 1 ☐ M 2 💢 F SOUTH CAROLINA Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show "natural", or items 23a or 28a-1 snov edical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE MARYLAND BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21207 U.S.A. 6615 WINDSOR MILL RD Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify: Specify: BLACK þ 72 hours 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) HUTLZERS DEPT STORE COOK 8th grade h and Mental Hygien 7 is marked other th permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY HILL MADDEN TOY MADDEN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6615 Windsor Mill Rd., Baltimore, Maryland 21207 Sharon Lewis/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-11-08 BALTIMORE, MARYLAND BALTO NATIONAL 21. Signature of Funeral Service Lic Alee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Drown Mellera 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner TEREMIT Sequentially list conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trans Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9∏Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig 20051024 YSICHAN

State Registrar

DHMH 17 Rev 1/2001

S601 LOCHRAVEN BLVD BALTIMORE, MD 21239-2995

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OMERS M.D.

31. Date filed (Month, Day, Year)

08-02623			
David Edwards			

2623 d Edwards		Please Type or Print in Black Indelible In		
o Lowards		State of Maryland / Department of Certificate of		ne 2008 146
Physicia dical Exami		Decedent's Name (First, Middle,Last)	Mo	te of Death nth Day Year 0.707 has
		Davia Laudias	tb. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		ate of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		217-76-9556 147 Yrs	Months Days Hours Min.	7.6.1960 Foreign Country) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on	10d. Inside City Limits
Maryland 28a-f show d at once.	tor	10e. Street and Number	Tof, Zip Code	1 Yes 2 No
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should be f and Mental 7 is marked	ToB		Address (Street and Number or Rural R	oute Number, City or Town, State, Zip Code)
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Deficiency, in permit. Pages I and Department of Health Important: If item njury or other trau		1 Burial 2 Cremation 3 Removal from State crematory or oth	ner place)	
permit. Page Department of Important: injury or oth		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensage 22. N		2008 Baltimore. Extion Services
		Vaughn C. Groone sis	51 Baltimore Nation	21 Pike Baltimore MD 21229
Physician /Medical		23a. Part I. Enterthe disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying, such as cardiac or respi	ratory arrest, shock, or heart proximate Interval Between Onset and Death
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	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	Examiner	(Disease or injury that initiated events resulting in death) Last C		
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death c	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	ner (Specify)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown
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te has b	Completed			autopsy prior to completion of cause of death? ✓ Yes 2 No 1 ✓ Yes 2 No
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Division of Vital Records, tal or Attending Physician: The law requirers after death. The tal Director: After this certificate has been sited in by the funeral director, page 2 should be riffication: To Be Completed		1 V Natural 5 Pending (Month, Day, Year)	njury 28c. Injury at Work? 28d. I	Describe how injury occurred
To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree		ocation (Street and Number or Rural Route Number, City
ospital hours a uneral ly filled		4 Homicide determined (Specify) 29a. Certifier		
the II thin 24 the Fi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation		
F. 18 E. 18	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		4 Mills	O.C.M.E.	April 4, 2008
- \		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Pen		21/1/17
	ate	31. Date filed (Month, Day, Year) APR 0 9 2008 32 Registrar's Signature	es and a second	
Regist	uali	HIN OU DOOD NOOD		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Robert Daniel Eastwood, Sr. 5:00 AM 2008 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1√2M 2□ F 214-64-8733 53 9-23-1954 Maryland Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Yes 2□No Maryland N/A Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3459 Hickory Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1XXYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2CXNo Specify: Completed by white XX Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Foreman Picture Frame Co. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Woodrow Eastwood Mildred Stanley ပို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (son) 3432 Hickory Avenue Baltimore, Maryland 21211 Robert Daniel Eastwood, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or oth Burial 2 Cremation 3 Removal from State Lake View Memorial Pk 4/11/2008 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lio Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Colorectal CANCER one year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-trar Due to (or as a consequence of): or Vital Records, P.O. Box 68760, physician death certificate be Physician/Medical attending p for use as as IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 Yes 2 No 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Yes 2 No page 2 has certificate 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Leath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending (Month, Day Year) 1 Natural Injury 5 ☐ Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)005239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Parkuly, Baltumore, MD 21218 Memorial Haspital Levis Union 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 16:30 2008 April 6, Dorothy Leona Eilman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country)
Oct. 25, 1916 Maryland If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 🕅 F 91 **Director** 213-09-5067 Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be 21015 USA 400 M Hazelnut Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Specify Specify: Completed by 3 Widowed 4 □ Divorced White 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Margaret Lijewski Leonard (nmn) Fisher Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 4740 F. Water Park Dr., Belcamp, Maryland 21017 Charles L. Eilman / Son Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition é 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. 4-9-08 4 □ Denation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Fundral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (DSSOCIATION Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con quence of): Examine Due to (or as a consequence of) physician Physician/Medical the attending property for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknow þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2: certificate has autopsy performed 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 3□ DOA မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 9 funeral Certification: 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division (Month, Day Year) Hospital or Attending 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Dave signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

4

DORUTH

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Registrar's Signature

GO, CATEWAY DKIVE, SW1621/22B,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EPSTEIN Physician /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Months 98 03/16/1910 Director 218-03-2330 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f shov ediral Exaπiner must be notified at 1 □Yes 2 No Directo MONTGOMERY ROCKVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 MONTROSE ROAD 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed by 3 M Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked LOUIS BLUMENSTEIN REGINA SCHOEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health THELMA E. WEINER / DAUGHTER 2704 MAURLEEN COURT, BALTIMORE, MD 21209 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State BNAI ISRAEL CONG. 04/08/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trans Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an cate has autopsy of Attending Physician: offer death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient Nursing Home 5 Residence 6 ☐Other (Specify) 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b, Time of 28d. Describe how injury occurred 5 Pending investigation 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

Jivision or Vital Records, P.O. Box 68760, completely filled in by the funeral

29c. License number
D 354 36 APRIL 06, 2008 de MONTROSERD, ROCKVILLE, MP 20852 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0 /Medical Facility Name (If ot institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Kalhmore DMS Randallstown If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2€7F Director 62 228-66-9142 01/05/1946 VA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2. and injury or other traumatic event, the Medical Examination once. USA by Funeral 3003 Ellerslie Avenue 21218 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Library of Congress Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Theodore Fetter Lillie Jameson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Leonard/Husband 3003 Ellerslie Avenue Baltimore, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Inc. 2008 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1443 Cremation and Funeral Alternatives Maryland 21286 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** mone Sequentially list conditions in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, physician the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has I autopsy performed? Yes 22 No or Attending Physician: 25. Was case referred to medical examiner? director Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence & Wother (Specify) 2 No 1 ☐ Yes 1 Nopatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 Natural 2 Accident ours after death.

neral Director; Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 hours a

To the Funeral I

completely filled To the Hospital

> h State

Medical

31. Date filed (Month, Day, Year) APR 09 Registrar

29b. Signature and title of certifier

30. Name and address of person who

2008

npleted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	oi waryiano /	•	riment of H Fificate of L			giene Reg. No	2008	11469
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Exami	ner	4a. Facility Name (If not institution, give street and FOREST HILL HEALTH AND				Location of Death			County of Death ARFORD	
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ter de Item	Funeral	Armed	Decedent Ever in U.S. I Forces? es 2 17 1 No	13. W	Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	·	14. Race - Ameri Black, White	
urs af	b	If Yes 3 🔀 Widowed 4 □ Divorced Year of	es 2 X No , Give or Dates:	1	□Yes 2X No	Specify:			Specify: Whi	.te
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Hygi Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)	, 1	TECT	rician	18. Mother's Name				ecci wip.
Jenual be Mental	To B	Thomas K. Fisher				Mary A.	. Krame	r		
2 should and Mer Is marke		19a. Informant's Name/Relationship (Type. Print)	19	b. Mailing	Address (Street a	and Number or Rura	al Route Numbe	er, City or	Town, State, Zi	p Code)
Ty widn y idning Z 1 Z 1 and 2 should be filed withi Health and Mental Hygiene, em 27 is marked other than ther traumatic event, the M						Court -				21014
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		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service LicentSee	Garde			Cem. 04/0				Maryland . Home, P.A.
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/Medical Examiner		resulting in death)	to (or as a conseque ce	of):						
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To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier Certifying Physician: To (Check only one) Medical Examiner: On the and r	the best of my knowledg ne basis of examination a nanner stated.	ge, death ind/or inve	estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	date and	and manner as place, and due	stated. to the cause(s)
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		Dave 5D	_>		035	277		Apr.	17,2	007
ý		30. Name and address of person who completed of DR. DAVID DUNN - 615 W	EST MACPHAI	L RO	AD - BEL	AIR, MD	21014			
Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 9 2008	. Registrar's Signature	Good	W					
				3						

Lance Derrell Fisher

08-02684 Lance Derrell Fis	her	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental Hy			0 1117
and Bonon . Ic		1- For State Certificate of Death	_	. No. 200	8 114/1
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Death	Day Year	3. Time of Death
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	Н	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1700 Van Bibber Road Rm. 268 Edgewood		Harford	
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Director		131-66-7653 1X M 2 F 25 Yrs. Months Days Hours Min.	03/31/1	.983 Foreign	NORTH CAROLINA
, ku	_ <u>_</u>	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County			10d. Inside City Limits
nd show:	۲	MARYLAND HARFORD CO EDGEWOOD			1 Yes 2 X No
daryla	~ L	10e. Street and Number 10f. Zip Code	109	. Citizen of What Cou	ntry?
a the N		618 HARRPARK CT. 21040		U.S.A.	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
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121 Id be f Aental narker event,	Be	ALVIN B. FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fig. 1)	ICCORMICE		e 7in Code)
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e, N and 2 Health item 2	ı	Carol Fisher/Mother 1040 Park Place, Brown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City o	r Town, State
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altin mit. P partme portar ury or	1	21 Ignature of Funeral Service Licensee 22. Name and Address of Facility		DUNDALK, I	
m		Pullana Chur WM C BROWN COMMUNI 321 S PHILA. BLVD). ABERDI	EEN. MD	21001
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xaminer	İ	Immediate Cause (Final disease or condition resulting in death) a. Alcohol and Oxycodone Intoxication Due to (or as a consequence of):			Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of):			
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Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance	ancy	23d. Date of delive Month	ry Day Year
ox 6 ath cer attendi	sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		osition of the state of the sta			obably 4 🗸 Unknown
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Sion (ttend death. ctor:	atic	2 Accident Investigation Fnd 4/6/08 Fnd 11:29a	Unk		1-1
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Cartifician Discription To the heat of my knowledge death accounted at the time date and place and		Bibbard RdI	
thin 24 the F	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a			
To with To con	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
		Coude Hallan O.C.M.E.		April 6, 2008	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)	M	· · · · · · · · · · · · · · · · · · ·	

State Registrar

31. Date filed (Month, Day, Year) APR 0 9 2008

Carol Allan, MD Assistant Medical Examiner

OCME

2. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Mildred L. Fratini 2008 12:30 A. 4 April 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie 406 Chalmers Avenue Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🗓 F 233 26 4399 87 04/10/1920 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Chalmers Avenue 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Cosmetician Montgomery Wards 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Harrison Mildred L. (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Richards / Daughter 406 Chalmers Avenue Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 04/07/2008 | Baltimore, Maryland Holy Cross Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Kione 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause oppach line. Immediate Cause (Final 0119 Carl disease or condition resulting in death) Due to (or a consequence of): Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 100 autopsy 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner burial-transit Box 68760, attending physicien for use as the burial P.O. F the þ Division of Vital Records. been Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice funeral filled in by 24 hours a To the within 2

Physician

/Medical

Examiner

Directo

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Funeral

Director

is marked other than "natural", or items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at

other t

Injury or permit. Page Department of Important: If any Injury or once.

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Examiner

Physician/Medical

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Completed

Certification:

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: It item 27 is marked other then "netural", or Ite

3altimore, Maryland 21215-0036

death with the Maryland

V

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

30. Name and add

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed cause of death (Item - a) (Type, Print)

29c. License number

1 🖵 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

32. Fegistrar's Signature

Madisan

amend State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner 56 Acorn timore 8. Date of Birth (Month, Day, Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year) 1 □ M 2 □ K Months 237-12-6480 Director · (aroliva Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director OWSON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Pages 1 and 2 should be filed within 72 hours after death American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ **(**0 Baltimore, Maryland 21215-0036 Be Completed by 3 ☐ Widowed 4 ☐ Divorced er than "natura , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than 'r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) CITY OF NEW erica 17. Father's Name (First, Middle, Last) Norman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. unghter TOWSON, M10 20c. Location - City or Town, of Health a Department of Health Important: If item 27 any injury or other tr once. Acorn Circle, Yargaret 20a. Method of Disposition 11 Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M01363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSOS **Physician** /Medical Due to (or as a consequence of): Examiner Tryphy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 \(\sum \text{Yes} \) 2 \(\begin{array}{c} \text{No} \\ \end{array} Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 🗖 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1☐ Yes 2☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ravem BIVI, Balt-MD71239 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 Musa 31. Date filed (Month, Day, Year) egistrar's Signature State APR 09 2008 Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene State of Maryland Department of Health and Mental Hygiene State of Maryland Department of Health and Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 25 WILLIE RENE GINWRIGHT 03 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 34/15bill Hicamica REGIONAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex (8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F Director 577-56-7127 67 2-28-1941 **GEORGIA** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 11XYes 2 □No Director MD P.G. CAPITOL HEIGHTS 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 5516 SHERIFF ROAD 20743 U.S.A. by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married ö Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK 3 ☐Widowed 4 ☐ Divorced natural", Completed the Medical 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th HOMEMAKER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be WILLIE JONES OSIERVELL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 FREDERICK GINWRIGHT - SON 5516 SHERIFF RD., CAPITOL HEIGHTS, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 □ Cremation 3 □ Removal from State 04-05-08 HARMONY MEM. PK 4 ☐ Donation 5 ☐ Other (Specify) LANDOVER, MARYLAND 22. Name and Address of FacilitRONALD TAYLOR II FUNERAL HM 21. Signature of Funeral Service Licensee 108 W. NORTH AVENUE, BALTIMORE, MD 21201 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK DAYS **Physician** /Medical Due to (or as a consequence of): Examiner Sepsis Days Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transi Due to (or as a consequence of): physician certificate be Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐Live birth that the death 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death o 9∏Unknown 9 ☐ Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed page Vital 1□ Yes 2☑No Hospital or Attending Physiclan: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 710 မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At hon building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) At home, farm, street, factory, office determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D0062916 MARCH MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

GUTTERREZ

2008

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32. Pajistrar's Signature

31. Date filed (Month, Day, Year)

1415 SOUTH DIVISION SUITE B SALISBURY MD 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** MELVA MAE GRAMMER APRTL 4, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RITCHIE HOSPICE BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 F Director 218-48-3521 62 5, 1945 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Examiner must be notified Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code JOSEPH RITCHIE HOSPICE 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10TH OFFICE PRIVATE STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ MELIN GRAMMER WANDA M. CHILDERS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUE SCHWARTZ/COUSIN 13068 WINTERSTOWN RD., FELTON, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 5500 O DONNELL ST. permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW 04/07/2008 BALTIMORE, MD 22 Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Juneral Service Licens 2007-09 EASTERN AVE., BALTIMORE, MD 21231 23a. Part1. Enter the disease shock, or heart failure. e, or complications the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause of each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Cause (Ulacase or injurthat initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown STAINING 24b. Were autopsy findings available prior to completion of cause of death?
1 □ yes 2 □ No 24a. Was an has s certificate has lirector, page 2 autopsy 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) No Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 [Other (Specify 27. Mannet of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 30. N ith, Day, Year) State 9 2008 Registrar 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician lor /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner NA Genera CRY And Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday **Funeral** Days Months 228-54-8141 1 M 2□ F 65 9/17/42 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 es 2 No NA Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 21216 3010 Normount Funeral - American Indian 12. Was Decedent Everth U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Neyer Married 2 Married 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Mechanic marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I nt: If item 27 is marked ot Joe ဥ Virginia Howard injury or other traumatic 19b. Mailing Address (Street and Number of Aural Route Number, City or Town, State, Zip Code)
3010 Normount Avenue Baltimore MD 21216 19a. Informant's Name/Relationship (Type. Pint) Desses 500 LISA Daugnter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 18/08 4 ☐ Donation 5 ☐ Other (Specify) Mount Crematori 21. Signatur of uneral Service Licensee 22. Name and Address of Fat Balto MU 2222 Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** tensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Examiner Reflux Disease signed by the attending physician Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform After this certificate 23 pt. // Division or Vital 2 No the Hospital or Attending Physician; 25. Was case referred to medical exampler?
1 ✓ Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA ဥ 1 🔲 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check onl) one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 413 commonweather AV, colons Ville all illie MUGUBA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

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Physici /Medi		Margaret Gra	ham				5, 2008	7:40 A ^M
Examir		4a. Facility Name (K) ot institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
	N/A	Morningside Assisted Living		Laurel If Under 1 Year	I lé l la des Od Lluc	[Prince G	
Funeral		1□M 2□F	In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Bii	rthplace (State or Foreign ountry)
Director		Usual Residence of Decedent	4 113.			April	17,1923 Nev	WIOTK
/land ow at			0c. City, Town or Lo	cation				10d. Inside City Limits
Mary I-f sh	tor	Maryland Prince George's	Laure1					1 □Yes 2X No
r 28a	Director	10e. Street and Number	IIII OI	10f. Zip Code			10g. Citizen of What C	ountry?
th wit 23a c	al	7700 Cherry Lane #213		20708			USA	
ems	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13. V	Nas Decedent of H	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
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withi ene. than	Į į	Elementary/Secondary (0-12) College (1-4or 5+)		maker	,		Own Home	
Hyg Hyg other ent, 1	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Surname)	
lid be lenta	To B	Charles Voges			Emilia K	orb		
shou and N	-	19a. Informant's Name/Relationship (Type. Print)					er, City or Town, State,	
and 2 alth a		Joan Humphreys Friend				et; Ell	icott City	, MD 21042
paritimiore, invary fattio ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other plac		Date	20c. Location - City o	
Dallillor Demit. Pages Department of mportant: If it any injury or once.		4 □ Donation 5 □ Other (Specify)	Arlington	Nationa	1 5/30/		Arlington,	
mit.		21. Signature of Funeral Service Livensee	177	Name and Address	_{ss of Facility} Ste me of Cat	rling A	shton Schw	ab Witzre
0 80 E # 9			1220 16	30 Edmon	dson Aven	ue; Cat	onsville,	
		23a. Part1. Enter the disease, or complications that caused the shock, or beart failure. List only one cause on each line.	e death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	aestic	ie	teart	Fa	ilare	Onset and Death
/Medical Examiner		resulting in death) Due to (or as a	equence of):		1	W		
LAdillilei	١.	Sequentially list conditions, b.		y o part	Thy			
sit ed	ije	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of).	7	,			
xecut and and	Examiner	that initiated events c.	consequence of):					
g physician and as the burial-transit	<u>8</u>							
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h certi ending		IF FEMALE: 23c. If yes, outcome pf					23d. Date of de	elivery
death death atte	icial	in the past 12 months?		∃Ectopic pregnancy] Other <i>(specify)</i>	/		Month	Day Year
by the	Physician/M	9 ☐ Unknown 9 ☐ Unknown						
VITAI THECOTOS, P.O. BOX OF Interest The death certificate has been signed by the attending prector, page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
law requires as been signe						1 🗆 \	res 2 No 3 ∏ F	Probably 4 Hinknown
aw re	plet					24a. Was	an 24b. Were a	autopsy findings available completion of cause of
The The late has bage	Completed					perfo	rmed? death?	
VICAL Ician: certifical ector, p	Be C	25. Was case referred to medical examiner?			26. Place of Deat	h <i>(Check only o</i>	ne)	
hysic his ce	일	1 Yes 2 No Hospital: 1 □ Inpatient	2 ER/Outpatien	nt 3□ DOA Oth	er: 4 Nursing Ho	me 5 Resid	dence 6 □Other (Sp	ecify)
ding Ph th. : After the funeral		27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day)	/ear) 28b. Time of Injury	Wor	y at k?	28d. Describe h	now injury occurred	
SIO teath. tor: A	catio	2 Accident investigation			Yes 2 □ No			
or At fiter d Direct	Certification:	4 Homicide determined 28e. Place of injury building, etc.	- At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tov	Street and Number or I vn, State)	Rural Route Number,
pital ours a eral c	20	29a, Certifier 1 Certifying Physician: To the best of	my knowledge deatl	h occurred at the tir	me date and place	and due to the	cause(s) and manner	ac etatod
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of each one) and manner state	xamination and/or in					
o the ithin (o the omple	Med	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
⊢≯⊢ŏ		Daniel lales	1)	00	5323	5	4/0/0	8
		30. Name and address of person who completed cause of dea	th (Item 23a) (Type.		J / L J		1 / 1 / 1 0	7
4			timore Av		urel. Mar	vland 2	0707	
St	ate	31. Date filed (Month, Day, Year) 32 Registrar	s Signature		,	,		
Regist		APR 0 9 2008 Brance	A A	BUR!				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Janet Louise Gerstmyer 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Loch Raven Center Baltimore County Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | October 13 1936 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Baltimore, Maryland 216 34 4373 71 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shedical Examiner must be notified 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 21136 306 Catata Drive Apt. 143 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐ Yes 2**X**2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X**XNo Saltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housekeeping-Own Home 18. Mother's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) Be Wilmer Miller Hilda Stiffler 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) June E Burczyk 4217 Valley Vista Court Manchester, Maryland 21102 of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metro Crematory Inc April 7 2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed the burial-tran attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) been signed by the a should be detached f 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Ûnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an page 2 autopsy perform 1∐ Yes 2 No or Attending Physician: Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature a

31. Date filed (Month, Day,

APR 0

30. Name and address of person who completed cause of 1100U 9 2008

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32. Registrar's Signature

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	Phy /M Exa	mi
Division or Vital Records, P.O. Box 68760, 😪	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and

		State of Maryla				_		e.		
		For State Registrar	Cer	rtificate of E	Death	Reg	g. No. 2	08 11478		
Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death		
/Medic	al	Frances Gilford 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	April	4 2008 4c. County of			
Examin	er	MD Masonic Home		Cockey			Baltimore			
Funeral		1 DM 2 DE	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear)	Birthplace (State or Foreign Country)		
Director		212-18-1870	115.			Aug. 28	1920	MD		
ryland how	_		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No		
he Ma 28a-f s otifiec	Funeral Director		Cockeysv	111e		100	Citizen of Wh			
a or 3	I Dir	10e. Street and Number 300 International Circle		210	30	10	10g. Citizen of What Country? USA			
death	nera	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of His If Yes, specify Cubar		ecity Yes or No-	14. Race -	American Indian, White, etc.		
s after	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 5 ☐ Year or Dates:		1 □ Yes 2√∑ No	Specify:	,	Specify:	white		
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lled will have the ther the nt, the	S	17. Father's Name (<i>First, Middle,</i> Last)	Offic	e Manager	18. Mother's Nam	e (First, Middle, M		rision		
ld be fental ked o	To Be	Carl W. Davidson				elle Hage	,			
2 shou and N Is mar aumat	_	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a						
1 and Health		Carol Suzanne Avirett/daughte	b. Place of Dispo	hilhowie				ity or Town, State		
ages ent of h tt: If ite y or o		1 M Burial 2 Cremation 3 D Bemoval from State	cemetery, crei	matory or other place emorial P	e) ¦	_	Cumberla			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Stylica Licensee				1		ley, Inc.		
B 3 E 6		Michael Plagle	\rightarrow 1	<u>O W. Pado</u>	nia Rd.,	Timonium	1, MD 21	.093		
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at the by the	hys	9 ☐ Unknown				T				
w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause give	en in Part I.		acco use contrib s 2	bute to the cause of death?		
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The law	отр	Nu Rangel inless	70 20 02	121 00-		autopsy perform 1□ Yes 2	pr. ed? de	ior to completion of cause of eath? □Yes 2☑No		
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pital cours af	Cel	29a. Certifier 12 Certifying Physician: To the best of my	knowledge, deat	th occurred at the tin	ne, date and place	and due to the ca	use(s) and man	ner as stated		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.								
To th withii To th	Me	29b. Signature and title of certifier		29c. License	e number	29	d. Date signed	(Month, Day, Year)		
i.		P.t. Julity, rus.	// es : =	1 221	46x		4/7/00	<i>y</i>		
4		30. Name and address of person who completed cause of death (Robert Liberto, Ms. 3508 Ba	(item 23a) (Type,	Beelt.	Mid 2	1220	/			
Sta	ate	31. Date filed (Month, Day, Year) Registrar's S	Signature	West .						
Registr	rar	AFR V 5 LOVO								

		1 - State of Maryla		rtment of Hetificate of L			giene Reg. No. 20	08 11479
Physici		Decedent's Name (First, Middle, Last) HARRY	GOL	DBERG		2. Date of De- Month APRIL		3. Time of Death 1:40P M
/Medio Examir		4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME		4b. City, Town, or BALTIMOR			4c. County of	Death
Funeral Director	~		s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da 05/25	h o	Birthplace (State or Foreign Country)
laryland show		Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Lo	cation				10d. Inside City Limits
he Mary 28a-f sh otified	Director		WINGS M				10g. Citizen of Who	1 □Yes 2 🕅 No
th with t 23a or 2 Ist be n		3440 ASSOCIATED WAY, #411	•	10f. Zip Code	1117		rog. Citizen of win	USA
17.15-5-UU36 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Arriged Forces? 1 Never Married 2 Married 11. Was Decedent Ever in Arriged Forces? 1 Never Normal Status 4 Divorced 12. Was Decedent Ever in Arriged Forces? 1 Never Normal Status 12. Was Decedent Ever in Arriged Forces? 1 Never Normal Status		Vas Decedent of His f Yes, specify Cubar □ Yes 2【 No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No Rican, etc.)	Black,	American Indian, White, etc. WHITE
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Ind Z1Z13-U be filed within 72 ho tal Hygiene. d other than "natu event, the Medical		Elementary/Secondary (0-12) College (1-4or 5+) 12		AUTO MECH	IANIC 18. Mother's Name	/Cimt 84iddle		MOBILE
	To Be	17. Father's Name (<i>First, Middle, Last</i>) DAVID G0	LDBERG		FANNIE	(First, Middle,	maiden Surname)	ROSEN
OCE, Maryla ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic.	ľ	19a. Informant's Name/Relationship (Type. Print) BEATRICE GOLDBERG / WIFE			ED WAY, #			
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To the within To the Comp	Me	29b. Signature and title of certifier January Lauren Lauren	lini	29c. License	28575-		29d. Date signed ((Month, Day, Year)
6		30. Name and address of person who completed cause of death (It	2	Print)	YE, Suit	E 203	, BALTO	MAZINA
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** tamil /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 X F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Expressure must be notified at 1 Kes 2 No Funeral Director altimore 10e. Street and Number 10g. Citizen of What Country? 23a or ISA och Raven 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify Black Completed by Specify 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21234 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other tracentee. Hamilton 6620 EnglishOa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses weral Services K Rd. Balt. MD 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ng, such as cardiac or respiratory arrest Immediate Cause (Final east **Physician** cano er with 6 MOS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this cartificate has been directored. burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 ☐ Yes 2 No 1 ☐ Yes Be (25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident nours after death. neral Director: / 1 Tes 2 ∏ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day,

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D. Towscutown

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Registrar's Signature

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Year)

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Please Type or

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Print in Black Indelible Ink. Ensure A of Maryland / Department of Health and	Mental Hygiene UUO 1140	
Certificate of Death	Pog No.	

Physician /Medical **Examiner**

Funeral Director

show at r 28a-f sh notified ms 23a or 2 must be n Examiner ould be filed within 72 hours after Mental Hygiene. ō permit. Pages 1 and 2 should be filled within 72 hc Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical

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21215-0036

Baltimore, Maryland

Box 68760,

Division or Vital Records, P.O.

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Physician /Medical Examiner

sician and burial-trans be exec the requires that the death certificate attending pl ed by the signed I page 2 s certificate director, this After this funeral c ne Hospital or Attending Pl n 24 hours efter death. ne Funeral Director: After the pletely filled in by the funeral completely

2. Date of Death 3. Time of Death Year Month 0045 AM Gertrude E. Hammond 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore FRANKLIN Square Hospital Center Rosedale 8. Date of Birth Aug. 9, 1926 if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 □ **X** 81 MD 214-22-0243 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County MD Baltimore 1 ☐ Yes 2 No Essex Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 307 Essex Avenue 21221 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Western Electric 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Hassell Nellie Lease မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Hammond 3502 Cornwall Court Baltimore MD 21222 / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4/8/08 Baltimore MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only page cause on each line. Approximate Interval Between Onset and Death pet enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Lung cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underl in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD rwks D0061907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

within 24

9000 FRANKLIN SQUARE DR Balto, Md 21237

M. Ebo

32. Registrar's Signature

ChukwumA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State amend #19a Per FH 0878 4/09/08 JH Cortificate of Basic Rea. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day 200 8 Physician 5:10 AM todges Hor. /Medical Facility Name (If not Institution, give street and hymber) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2altimore Woodbridge atonsvi are 7. Age (In yrs. last birthday) Yrs. If Under 24 Hrs. 8. Date of Birth Month Pay, Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex **Funeral** 231-26-7255 Min 1 □ M 2 🕱 F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 229 Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. filed within 72 hours after of Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4or 5+) Thin 0 10/th mstres Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Hers Synobia R. Bracksond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter) 1217 Kent

20b. Place of Disposition (Name of Cemetery, crematory or other parts) Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State .08 4 Donation 5 ☐ Other (Specity) 21. Signature of Funeral Service Licensee Funeral Ses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG ADENDCA RCINOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical page 2 should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 1 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 010059107 M. L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DAIVE REISTERS TOWN

State Registrar MA

31. Date filed (Month, Day, Year) APR 0 9 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month and. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** -bspita tai Inder 24 Hrs 8. Date of Birth (Month, Day, Year) 8-22-1932 If Under Months 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 1 ☐ M 2 F 219-28-8481 Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 Yes 2 No ıral", or Items 23a or 28a-f sł Examiner must be notified Directo M 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Dicedent Ever in U.S. Armed Forces? Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 100 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify Completed by 3 Widowed 4 Divorced "natural", er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Segnarol 20a. Method of Disposition D.MD 2/2/2 20b. Place of Disposition cemetery, crematory ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. ng, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and is the burial-trans el Be Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No 24a. Was an funeral director, page 2: the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1niury 1 Natural 1 ☐ Yes 2 □ No 2 Accident after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 X/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sireesh K. Tripuraneni Good Samaritan Hospital Hospital 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

APR 0 9 2008

DHMH 17 Rev 1/2001

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	Physici /Medi		Catherine V. Haywood			04, 2008	1:00 P.M
	Examir	er		o. City, Town, or Location of Death		4c. County of Death	
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	rylan how	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
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	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was	Decedent of Hispanic Origin? (Spis, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	can Indian, etc.
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Baltimore, Maryland 21215-0036	it Pa trimer ritant njury			Cemetery 04/08		lkesville,	
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny Injury or other tres			ame and Address of FacilityLord 8 Liberty Road,			
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	in		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	1)		Co	con he o
	5		Shakunmale gupte 9650	00053150 Sentigo Rd	Suite	110	2045
	Sta		31. Date filed (Month, Day, Year) APR 0 9 2008 32 degistrar's Signature				
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George Rossite		Cate of Maryland / Department of		Hygiene	2008 11485			
Physici		1- For State Certificate o Registrar 1. Decedent's Name (First, Middle,Last)	i Dealli	Reg. No.	3. Time of Death			
Medical Exami		GEORGE ROSSITER HESSE		Month Day April 5, 2008	Year 1704 hrs			
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	ath 40	c. County of Death			
Funcant		Good Samaritan Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24H	ire IS Date of Right AAA	None //DD/YYYY) 9. Birthplace (State or			
Funeral Director		215-40-8588 XX _{M 2} F 65	Months Days Hours M	05/11/19	Foreign			
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits			
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ith the 23a o		6125 Haddon Hall Road 11. Marital Status 12. Was Decedent Ever in U.S. [13. W.	21212	Specific Ven ex No.	USA			
eath w items ust be	Funeral	1 Never Married 2 X X Married Armed Forces?	as Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc.			
after d al", or	by Fi		Yes 2XX No specify:		Specify: White			
hours natur	edt	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	nt's Usual Occupation (Give kind on nost of working life. DO NOT use r		Kind of Business/Industry			
36 hin 72 e. than "	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	rector of Finan	CA	Railroad			
5-0036 iled within 7/ Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)		me (First, Middle, Maider				
121. I be fil ental F arked vent,	Be	William James Hesse		garet Mary I				
MD 21 d 2 should 1 lth and Mer n 27 is mar tumatic eve	٢		ng Address (Street and Number of Haddon Hall Rd		· · · · · · · · · · · · · · · · · · ·			
		20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery,		Location - City or Town, State			
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 Bunal 2 XXcremation 3 Removal from State GreenMoun		-10-2008 Ba	altimore, Maryland			
altin mit. P partme portar ury or	1				Funeral Home Inc			
	1	MMB & Hanen & Elleris	6500 York Ro	ad Baltimore	e, Maryland 21212			
Physícian /Medical		23. Part I. Enter the Heast or complications that caused the death. Do not enter failure. List only one cruse on each one.		c or respiratory arrest, sh	Between Onset and			
xaminer		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Dis	sease		Death			
		Sequentially list conditions, b						
	iner	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.						
\ = =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
executed an and al - transi	cal E	d.						
50, te be e sysicia	/ledi	IF FEMALE: 23c. If yes, outcome of pregnancy		1 23	Bd. Date of delivery			
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic preg		Month Day Year			
SOX leath c e atten for us	ysici	1 Yes 2 No 9 Unknown Pregnant at time of death 5 0	ther (Specify)					
P.O. Box s that the death med by the atter		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?			
cords, P.O law requires that has been signed be detailed be detailed by the control of the detail of	d by			1 Yes 2	No 3 Probably 4 ✔ Unknown			
Cords law requesters been the property of the	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
Rec The la icate h	E O			performed?				
ital Recician: The sectificate	Be	25. Was case referred to medical examiner? Hospital: 1 Innation: 2 FE/Outpation	26.Place of Death (Che					
of Vi g Phys her this eral di	-T	1 ✓ Yes 2 No Tospital 1 Inpatient 2 ✓ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of	t 6 Ben 4 Ita	sing Home 5 Resid	ence 6 Other:			
Division of Vital Records, tal or detending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	tion	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No					
ViSi or Att frer de Direct in by	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	eet, factory, office building, etc.		and Number or Rural Route Number, City			
Di spital tours a neral I	Certification:	4 Homicide determined (Specify)		or Town, State)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occu						
To the within 2 To the complet	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)			
		his his mid	O.C.M.E.		ril 6, 2008			
		30. Name and address of person who completed cause of death (Item 23a)						
12		Ling Li, MD Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21201					
	ate	31. Date filed (Month Day, Year) 2008 Registrar's Signature						
Regist	nen							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 5:38PM [™] 6, Patricia Hasert April 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Reisterstown 115 W. Chestnut Hill Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March15,1930 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1 M 2 F MD 78 215-28-1140 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 No by Funeral Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21136 115 W. Chestnut Hill Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk MD State Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sherman Wisner Ruth Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 S. Narberth Ave., Narberth, PA 19072 Linda P. Hasert Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. 4/12/08 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home 23a. Part1. Enter M. seese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACCINOID UMOF Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2. ■ Yo Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ¥6 24a. Was an autopsy performed? 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 21**X**No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

e attending physician and d for use as the burial-transit The law requires that the death certificate be executed Jivision or Vital Records, P.O. Box 68760, the detached signed by should be has been page 2 director, this or Attending after death filled in by To the Hospital of within 24 hours af within 24 hours a To the Funeral I

Physician

/Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentai Hygiene.

permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainment.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

Be

Medical Certification: To

29a. Certifier

(Check only one)

W. Ilian

29b. Signature and title of cartifier

31. Date filed (Month, Day, Year)

APR 09

2008

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shair

1071 32 Registrar's Signature Red

1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

038209

#415

Lotherille

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** APRTL 2008 HEIFETZ 6:35 AM ROSE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARMONY HALL ASSISTED LIVING COLUMBIA HOWARD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 04/28/1913 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🛣 F 103-10-0264 94 Director POLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD HOWARD COLUMBIA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 CEDAR LANE, APT. 309 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No ARMY If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: WHITE Specify. ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry VETERANS ADMINISTRATION Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEVITT MEIER LEAH 2 ROSINSKY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau DANIEL HEIFETZ / SON 5209 KALMIA DR., DAYTON, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP.04/07/2008 TOWSON, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Juneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if he, it failure. List only one cause on each ling. Immediat Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e attending physician and d for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Month Year Day 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **™**Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy perform Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 6 Other (Specify) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation 1 Yes 2 No neral Director: A filled in by the fu

State Registrar

2

Medical

6 ☐ Could not be

determined

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who

APR 0

within 24 hours a

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my opinion death accurred.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

sician and burial-transit signed by the attending physician d be detached for use as the buria this funeral death. Director: after

3altimore, Maryland 21215-0036 Elementary/Secondary (0-12) Glen L. Martin Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilton Marion Unknown Oscar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Treeway Court #2A Towson, Md. 21286 Mrs. Grace Hilton/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hillton Service Co. 4-14-08 Towson. Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Lice see se, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the dise shock, or heart failur Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION Physician /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Ves 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes CHRONIC RENAL FAILURE 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No perforn To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Be Hospital: 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Commedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31826 NICHK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 M. D. 31. Date filed (Month, Day, Year) 32. gistrar's Signature State APR 09 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Center

7. Age (In yrs. last birthday)

10c. City, Town or Location

Towson

89

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

10f. Zip Code

1 ☐ Yes 2 X No

21286

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | Min. | March 15,

Reg. No. 4

, Year) 5 1919

10g. Citizen of What Country?

Specify.

16b. Kind of Business/Industry

201218

4c. County of Death

2. Date of Death

Month RIL Day

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Maryland

USA

White

14. Race - American Indian,

Black, White, etc.

11:31AM

1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number) 5. Social Security Number

Charles

10b. County

12 Treeway Court #2A

1 Never Married 2 Married

3 Widowed 4 Divorced

Baltimore

15. Decedent's Education (Specify only highest grade completed)

W.

1X M 2□ F

6. Sex

Hilton

12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

Director 10e. Street and Number

Md.

11. Marital Status

Funeral þ Completed

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 126 ORT **JAMES** JOHNSON 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner MORYANA 5. Social Sekurity Number Saltimore 7. Age (In yrs. last birthdav If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 12XM 2□F Director 84 250-30-8299 MAY 15 1923 SOUTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at ral", or items 23a or 28a-f sh Examiner must be notified 1 X Yes 2 □ No Director MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 301 McMECHEN ST. **APT 424** 21217 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ ★es 2 ☐ No If Yes, Give Year or Dates: 43/46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify: BLACK Pages 1 and 2 should be filed within 72 hours ament of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", cury or other traumatic event, the Medical Exan 31XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHAM STEEL 8th grade LOADER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို CLAYTON JOHNSON MARY COOPER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Huntersforge Ct., Owings Mills, Md., 21117 Glynis Johnson/Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department fon 5 ☐ Other (Specify) GARRISON FOREST 04-10-08 OWINGS MILLS, MARYLAND 21. Si privire of Fugeral Service Liger 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Darlara 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed . Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an Was a... autopsy performed? Yes 2 No page 2 certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Certification: To 1 Tyes 1 Impatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide the Hospital hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Muhammad 31. Date filed (Month, Day,

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 9:59PM MARCH 31 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 600D HOSPITM If Under 1 Year | If Under 24 H Months | Days | Hours | Mi SAMAR ITAN Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year)
8-20-1932 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Min. 227-40-4537 Director ma Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 21 is marked other than "natural" or incorrer any injury or other trainmain. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □ 💢 s 2 🗆 No Funeral Director ltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code everall 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 💥 No Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) College (1-4or 5+) WOTKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surrame) To Be 19a. Informant's Name/Relationship (Type. Printi Dung Liver) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 1784 730 Meyer Field (+. Eldersburg, AL

20c. Location - City or John, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State Garden OF Facklene Baltimore, MD 21. Signature of Funeral Service Licensee - Mo1363 + Rd · Ba 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dissemenate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ R18712 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 100 P 1 ☐ Lopatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 776 ND154 20060139 PETSICIAN' ARRIL 2008 DK MAN N. WO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amar 17 Ans HUSPITAZ,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 0 9 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:45 P M 3_ 2008 Carl (nmn) Justo Sr. April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford 504 Brians Garth Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. **№** М 2 П F 586-60-6544 Philippines Director 74 21, 1933 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 504 Brians Garth 21015 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX'es 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2K No Specify Specity: Filipino 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugo V. Justo Innocencia (nmn) Didicatoria 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lourdes Justo / Wife 504 Brians Garth, Bel Air, MD 21015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signatur of Funeral Service Lice Hilltop Service Corp. 4-8-08 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part I. Enter the disease, or combilinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FAILURE KENAL /Medical Due to (or as a consequence of) **Examiner** WIOTHSIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed PERPHERA burial-tran Due to (or as a consequence of): hecords, P.O. Box 68760, physician Physician/Medical the IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown ģ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1∐ Yes 201No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? al or Attending P s after death. Il Director: After t 28d. Describe how injury occurred (Month, Day Year) Injury 1. Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on опе) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month. Dav. Year) 4-4-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

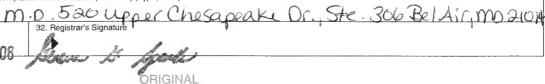
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State Registrar

APR 0 9 2008

Mark Gonze

31. Date filed (Month, Day, Year)



08-02496 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 11492

		- For State				Certifica	ate of	Death					Reg.	No.		
Physicia		Registrar 1. Decedent's Name (First, Mi	ddle,Last)									2. Date of Month	D:	ay Yea	ır	3. Time of Death 0523 hrs
Exami		RONALD				<u>OYNER</u>		March					30, 20	4c. County	of Deat	<u> </u>
		4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital 4b. Recility Name (if not Institution, give street and number) Baltimore								n/A						
					9 4 - //-	land bird	h day)	If Under		If Under	24Hrs	8. Date	of Birth (1 g. Bi	rthplace (State or
Funeral		5. Social Security Number	6. Sex			yrs, last birt	nday)	Months	Days	Hours	Min.	1		1980	Forei	gn ountry) MD
Director		219 96-2714	1X M	2F	27		Yrs.			1.1		NOV.		,1900		ountry) [v][)
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death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number	TCON	CI	m				.oue 1205							,
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eath with the items 23a ust be noti	Funeral	11. Marital Status	Married 12	2. Was De Armed F			13. Was	s Decedent es, specify	Cuban,	Mexican,	Puerto F	Rican, etc	.)		e, etc.	model modelly blacky
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215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (S Elementary/Secondary (0-			(1-4 or 5+)	100.	during mo	ost of worki	ing life. I	DO NOT L	use retir	ed)				
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with with Brer th	E	17. Father's Name (First, Mid	dle Last)				LADC	NEK	1	8. Mother's	s Name	(First, Mi	idle, Ma	iden Surnam	e)	
filed all Hy	Be C	LARRY WAL								S	HEI.	BY .	EAN	IYOL I	ਰਜ਼ਨ	
21215-0036 unld be filed within 7 Mental Hygiene. marked other than cevent, the Media	9 B	19a. Informant's Name/Relati		e, Print)		19	b. Mailing	Address	(Street	and Num	ber or R	Rural Rout	e Numb	er, City or To	wn, Sta	ite, Zip Code)
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T te fee a tr	0.11	20a. Method of Disposition				20b. Place	of Dispos	ition (Name	e of cem	netery,		Date		20c. Location	- City	or Town, State
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Baltimore permit. Pages 1 Department of 1 Important: If injury or other					(110	(N	114	115 E	a E	DRES	KUG TON	ርይ 1 ጥጋ	TAUU	I TAN	MOF	21212
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Jedical	(i)	failure. List only one ca	use on each	line.	tab Wou											Death
Examiner		Immediate Cause (Final dise or condition resulting in deaf			a consequ											
		Sequentially list conditions,	b										_			
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recuted		events resulting in death, E	d													
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burialransis	Medical	UNPENDED	x	AMENDE	Ttom	#20b,1	norFL	1 C878	8 4/	15/0	8 WS	3				
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587 srtific fing p		23b. Was decedent pregnant past 12 months?	in the	Dec.	e birth	ne of death		etal death		Ectopi	c pregna	ancy		Month		Day Year
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To the Hos within 24 h To the Fun Completely	<u>8</u>	29a. Certifier 1 Certifyi (Check only one) Medica	ng Physicia LEvaminer:(n: To the l	best of my	knowledge, (ination and/o	death occi or investig	urred at the ation, in m	e time, d y opinio:	iate and pi n, death o	iace, an iccurred	at the tim	ne caus e, date	e(s) and man and place, ar	id due	to the cause(s)
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7	1	30. Name and address of p						1 Penn S	Street	Baltim	ore M	ND 2120	01			
5		Tasha Greenberg				I Examine	- 11	i i eilii s	Jueet,	- Daimil	J. G., IV		•			
	State		0000		Registrar'	s Signature	done	K								
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DHMH 17 Rev 1	/2001			2011			ŠRIGIN.	AL								

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Mary		tificate of			Reg. No.	2008	11494
Physic /Med		1. Decedent's Name (First, Middle, ABRAHAM	Last)	KING			2. Date of De	ath Day 5	2008	3. Time of Death 12:45PM
Exam		4a. Facility Name (If not institution, SINA) HOSPITA		IORE	4b. City, Town, o BAZ 77	Location of Death	n	4c. (County of Death	
Funera Directo		5. Social Security Number 216-07-1608		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month Da 06/06/	1918	9. Birth	place (State or Foreign ntry) POLAND
iryland ihow i at		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Lo						10d. Inside City Limits
the Ma 28a-f s	recto	MD BAL 10e. Street and Number	TIMORE	В	ALTIMORE 10f. Zip Code			10a. Citiz	en of What Cou	1 □ Yes 2 No
ath with 23a or ust be	Funeral Director	1 HIGHSTEPPER	-		2:	1208		l	JSA	
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? d 1 ☐ Yes 2 N No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cuba I□Yes 2X No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)		4. Race - Americ Black, White, Specify:	
215-C	Completed	15. Decedent's (Specify only highest Elementary/Şecondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of wor	rking	16b. Kin	d of Business/In	dustry
1212 lied with dygiene ther tha		17. Father's Name (First, Middle, La		PROP	RIETOR	18. Mother's Nar	no (Eirot Middle		S CLOTH	IING
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Baltimore, permit. Pages 1 ar Department of Hea mportant: If Item 3		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	B Removal from State A	Ob. Place of Dispo RICTAGE CON MUNO CON	GREGATION		Date 7/2008	BAL	TIMORE,	MD
Baltimo permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Li	censee CHHI		Name and Addre		SOL LEVÍ N ROAD -			, INC. MD 21208
Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition						rrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	a. RESPIR Due to (or as a cor METAST	nsequence of):	ROSTATE	CANO	ER			4 DAYS
p) isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con		•					
Box 68760, eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of):						
C 68760 rtificate be e on physician as the burie	Medical	IE EENALE.	d							
the d	Physician/IV	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							3d. Date of deliv Month	ery Day Year
Records, P. he law requires that e has been signed by	ed by Pt	Part II. Other significant condition CONGESTIVE CHRONIC OB	s contributing to death but no	t resulting in the ur	derlying cause giv	en in Part I.		obacco us Yes 2		he cause of death?
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Or Vital Physician: The this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Outpatient	t 3 DOA Oth		ath <i>(Check only c</i> lome 5 ☐ Resid		□Other (Speci	fv)
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DIVISION OF all or Attending Physical Section 1. Birector: After this din by the funeral	Certification:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	be 280 Place of injuny	At home, farm, stre pecify)		163 2 110	28f. Location (3 City or Tox		Number or Rura	al Route Number,
DIVI. To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the best of my caminer: On the basis of examiner stated.	/ knowledge, death mination and/or inv	occurred at the tire vestigation, in my o	me, date and place pinion, death occu	e, and due to the arred at the time,	cause(s) a date and	and manner as s place, and due t	stated. o the cause(s)
To the within To the Comp	Me	29b. Signature and title of certifier	ai Me)	29c. Licenso		00		signed (Month,	
20		30. Name and address of person wi	no completed cause of death	(Item 23a) (Type, F	Print)			4.		
St.	tate	31. Date filed (Month, Day, Year)	A OPBA P 32. Registrar's S	Signature	130	ELVEDE	EE AVE	BH	TIMOR	E MD 2121
Regis DHMH 17 Rev 1/	100	APR 0 9 20	08 Charas	y Apan						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Patrick C. Lauer 7:30 AM 4 08 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Balhmor Rosedale Franklin Square Hospital

5. Social Security Number 6. Sex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 6, 1956 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1**X** M 2 □ F 218-70-6252 51 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 831 Lannerton Road USA 21220 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larry C. Lauer Mary Lunceford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lauer / mother 831 Lannerton Road Balto. MD 21220 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Gardens of Faith 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4/9/08 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that cau be the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Shock Die to (or as a consequence of): reumonia Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physician for use as the buria

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this

Director:

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

hours after Funeral

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural",

other than

Is marked

permit. Pages 1 and 2 s
Department of Health as
Important; if item 27 is
any injury or other trau

injury or other traumatic

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

Directo

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

2

Certification:

Medical

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Leukocutoclastic vasculitis, atrial fibrillation, morbid

obesity, Ehronic obstructive Pulmonary hypertension rtspiratory Failure WITH Tracheoston

24a. Was an autopsy performed? Yes 2 No 1∐ Yes

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 TYes

2 No 3 Probably 4 Unknown

Chronic 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

27. Manger of Death 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 28b. Time of Injury Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

28c. Injury at Work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

4 ☐ Homicide

1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive Baltimore MD

29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/200

			For State Registrar	State of	Maryland		artment of				giene Reg. No.	008	1495	
	Physici /Medic Examir Funeral		1. Decedent's Name (First, Middle, Last) Frances Louise Lalak						2. Date of Death Month Day		Year	3. Time of Death		
A C			4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			White (4c. County			
			2502 Burridge Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)						8. Date of Birt	Date of Birth		1timore 9. Birthplace (State or Foreign		
	Director		215–10–5931 1	□M 2 ∑ F	93	Yrs.	Months Day	Hours	Min.	Feb. 18	3, 1915	Mary	<u>1[</u> (Y)	
	yland or at		10a. State 10b. County		10c. City,	Town or Lo						1	0d. Inside City Limits	
	he Mar 18a-fsl otified	by Funeral Director	Maryland Baltimore Parkville										1	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 2502 Burridge Road									g. Citizen of What Country? USA		
			11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri				cify Yes or No- Rican, etc.)	es or No- 14. Race - American Indian.			
		Completed	(Specify only highest grade completed) (Giv				kind of work done during most of working DO NOT use retired)					6b. Kind of Business/Industry Crown Cork and Seal		
		To Be C	17. Father's Name (First, Middle, Last,)			RIVELE		er's Name	(First, Middle,			and Seal	
			Walter Mc Fadden				- Address (C4::	Hanorah Cunningham g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
										ral Route Number, City or Town, State, Zip Code) Parkville, Maryland 21234				
			20a. Method of Disposition ★Surial 2 ☐ Cremation 3 ☐	Removal from Sta	ate <i>cei</i>	metery, crer	sition (Name of natory or other p			ate	20c. Location	- City or To	own, State	
턡	nit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (Specification of Specification o		Par		Cemeter Name and Add	ress of Facili			19		Maryland	
ă	Der Imp		Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and good completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or burial-transit.	iner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cau one cause on eac		Do not ente	Pr the mode of d	ing, such as	cardiac or	respiratory ar	rest,	_	Approximate Interval Between Onset and Death	
			resulting in death)	Due to (or	as a conseque	ence of):			11				0 9-56-1	
			Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	Due to (or as a consequence on):									
0,		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	as a consequence of):										
68760,		Medical Certification: To Be Completed by Physician/Medical		d					_					
Box			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ⅵ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1								23d. Date of delivery Month Day Year		
rds, P			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						l.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown				
Vital Records, P.O										24a. Was a autop perfor	sv		psy findings available mpletion of cause of 2 No	
Division or Vita			25. Was case referred to medical examiner? 1											
			27. Manner of Death 1 Natural 5 □ Pending	28b. Time of Injury				8d. Describe h			y)			
			2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	M 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
			29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
ì			29b. Signature and title of certifier Combin way Resemble MD					23:000				d. Date signed (Month, Day, Year)		
	3		30. Name and address of person who completed cause of death (Item 23g) (Type, Print) Carlo Welf Rosen that W.D., 608 Edgevall Road, Bultimore MD 21210											
7	Sta Registr	_	31. Date filed (Month, Day, Year) APR 0 9 2008	32. Reg	istrar's Signatu	falls	2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2008 ear April YOOK LEE /Medical 1:51 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 China Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1**∑**M 2□ F Months Days Hours Director 530-20-3924 Nov. 19, 1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4000 Eland Road 21131 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Chinese 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years <u>Proprietor</u> Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk. ၉ unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lawrence Lee (son) 4000 Eland Road Phoenix, Maryland 21131 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XI Burial 2 □Cremation 3 □Removal from State Dulaney Valley Memorial Grdns. 4-12-08 4 □ Donation 5 □ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part1. Enter the 3 iseas shock, or hearthailure. 21212 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tacky cardia Ventricular disease or condition resulting in death) min /Medical Due to (or as a consequence of): Examiner mon. heart Loronary Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed mellitus Dia beter signed by the attending physician and de detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heart 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Ûnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No certificate has be rector, page 2 s 24a. Was an Gastro-intestina 2 No 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No within 24 hours after geaun.

To the Funeral Director: After this completely filled in by the funeral dir မှ 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Stephen R.

31. Date filed (Month, Day, Year)

APR 09

DHMH 17 Rev 1/2001

Harford Road,

D-14957

Baltimore,

4-6-08

(MD)

8709

James 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith.

2008

MD ,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND THEM'S per FH C878 4/9/08 WS
State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year ROXANA LEADERMAN APRIL РМ 4 2008 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date Birth (Morah) Day, Year) **Funeral** Hours Days 1 □ M 2 N F 061-22-6030 Yrs 91 Director 11/23/1916NJ Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notion." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No MD Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 4730 ATRIUM COURT 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: WHITE ò 3 MWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN WOLPERT 2 ETHEL GOLDBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR LEADERMAN / SON 4322 WOODBERRY STREET, UNIVERSITY PARK, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONG. 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 04/07/2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 sease of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. 23a. Part1. Ent the disease shock, or leart failure. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) **Physician** Atheroscherotic Cerebral vascular 1 Pairs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1∐ Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5,2008 D37573 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 35 Main Reislevstown MD Zibel1 Mb 57. 21136

DHMH 17 Rev 1/2001

State Registrar 2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day 2008 **Physician** MURRAY 7:26 pM APRIL JOHN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months 142-46-839 Usual Residence of Decedent 1X M 2□ F 56 04-17-1951 VIRĞINIA Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No CLINTON Director MD P.G. 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 20735 12510 TOVE ROAD Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X ves 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛛 No altimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NAVY 12th SEAMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEWIS Α. DOLORES MURRAY, SR. ၉ 19a. Informant's Name/Relationship (Type. Print) BROTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6575 DOBBINS CT., LAPLATA, MD BILLIE R. MURRAY, JR. permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other th 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial A☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD RIVERDALE CREMATORY 4-8-08 21. Signal re f Funeral Service Licensee 22. Name and Address of Facility RONALD TAYLOR II FUNERAL HM 10583 MIDDLEPORT LANE, WHITE PLAINS, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final IVER **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine ANEMIA The law requires that the death certificate be execute Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial COAGULOPATH Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No s certificate has l lirector, page 2 s 1□ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

i Director: /
d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 orsampor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SISOM OSIA, 6192 OXON HILL ROAD #500 OXON HILL 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0-9 2008

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar